Welcome To Our Practice

Holly Downes, D.D.S.
7 North Knoll Road, Suite 6
Mill Valley, CA 94941

In order for us to provide you with the best care possible, please take the time to read and complete the following information. Thank you.

Patient Information

First Name: _____ Last Name: _____ Pref. Name: _____

Address: _____ City: _____ State: ___ Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ Soc. Sec. #: _____ Driver's Lic #: _____

Occupation: _____ Work Address: _____

How did you find out about our office? _____

Responsible Party (if someone other than Patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City: _____ State: ___ Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____

Birth Date: _____ Age: _____ Soc. Sec. #: _____ Driver's Lic #: _____

Primary Insurance Information

Name of Insured: _____ Relation to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec:_____ Insured Date of Birth _____

Employer: _____Insurance Company: _____

Address: _____ Address: _____

City/State/Zip: _____ City/State/Zip: _____

Secondary Insurance Information

Name of Insured: _____ Relation to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec:_____ Insured Date of Birth _____

Employer: _____Insurance Company: _____

Address: _____ Address: _____

City/State/Zip: _____ City/State/Zip: _____