Tillman Family Dental DMD, PC

Patient Information

Name_____Social Security #_____-____-_____
Last First Middle

Date of Birth_____Marital Status (check one): Single___ Married___ Divorced___ Separated___

Home Address_____ _____ _____ Home Phone (___) _____-_____
Street City State Zip Code

Email Address _____ Cell Phone (___) _____-_____

Employer_____Occupation_____

Spouse/Parent_____Social Security # _____-___-____ Date of Birth_____
Name

Spouse Employer_____Address_____ Work Phone (___) _____-_____

If someone other than the patient is responsible for payment, complete the following:

Name of the responsible party_____Address_____

Relationship to patient _____ Social Security # ____-____-____ Date of Birth_____

Employer/Employer Address _____ Home Phone (____) _____-_____

In Case of EMERGENCY

Relative to contact (other than spouse)_____Home Phone (____) _____-_____

Other person to contact (not relative) _____Home Phone (____) _____-_____

How do you intend to pay? Cash___ Check___ Credit Card ___ Insurance ___ CareCredit ____Other___

Primary Insurance Co._____Address_____Phone (____) _____-_____

Name of Insured_____ID#_____Group#_____

Secondary Insurance Co._____Address_____Phone (____) _____-_____

Name of Insured_____ID# _____Group#_____

Please sign and return to the receptionist.

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this visit or subsequent visits, I agree to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the dental clinic to release information necessary to secure payment of benefits and authorize my insurance benefits to be paid directly to Tillman Family Dental. I hereby authorize the dental clinic to obtain a credit history before, during and/or after any rendered treatment.

_____ _____
Signature of patient or parent/legal guardian Date