TCB Dental, LLC

Patient Name _____ Date _____
First M. Last

Marital Status: Single Married Divorced Widowed Separated Domestic Partner

Male/Female SSN_____ Birthdate_____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

Patient or parent's employer _____ Work Phone _____

Business Address _____

City _____ State _____ Zip _____

Spouse or parent's name _____ Employer _____ Phone _____

If patient is a student, name of school/college_____ City _____ State _____

Who is your primary medical doctor? _____

Person to contact in case of emergency _____ Phone _____

RESPONSIBLE PARTY

Name of person responsible for this account _____ Relationship_____

Address _____ Home Phone _____

Birthdate_____ Is this person currently a patient in our office? YES NO

Employer _____ Work Phone _____

INSURANCE INFORMATION

Insurance Company _____ ID# _____ Group # _____

Insurance Address _____City _____ State _____ Zip_____

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security Number _____

Name of Employer _____ Work Phone _____

Do you have additional insurance? YES NO If yes, please complete the following:

Insurance Company _____ ID# _____ Group # _____

Insurance Address _____City _____ State _____ Zip_____

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security Number _____

Name of Employer _____ Work Phone _____