TLC Dental Patient Information Sheet

Welcome and thank you for choosing our office for your dental care! Please take a moment to completely fill out the information below, which will help us to meet your needs. If you have any questions, please do not hesitate to ask!

PATIENT INFORMATION

First Name: ______________________________ Last Name:________________________ Middle Init.:_______

Preferred Name: _____________ Who is responsible for your account: _________________________________

Address:_________________________________ City: __________________ State:________ Zip:___________

Home Phone: _______________ Work Phone: ____________________ Cell Phone: ______________________

Circle: Male Female Marital Status (circle): Single Married Separated Divorced Widowed

Birthdate (mm/dd/yy):______________ Social Security #:_____-_____-________ Driver License #_________

Email Address: ____________ Emer Contact/relationship: ____________ Phone: ________________

RESPONSIBLE PARTY – the person financially responsible for your account

First Name: ______________________________ Last Name: ________________________ Middle Init.:________

Employer: _______________________________ Relationship to Patient: _______________________________

Address: _________________________________ City: __________________ State:________ Zip:___________

Home Phone: _______________ Work Phone: ____________________ Cell Phone:______________________

Circle: Male Female Birthdate (mm/dd/yy):_____________ Social Security #:_____-_____-_________

INSURANCE INFORMATION – please provide a copy of your insurance card

Full Name of Policy Holder: _____________________________ Relationship to Patient: ___________________

Address: ____

Home Phone: _______________ Work Phone: ____________________ Cell Phone: ______________________

Birthdate: _________________ Social Security #______-_____-______ Occupation:___________________

Employer: ________________________ Employer Address: ____

Insurance Company:_________________________ Group Number:_________________________________

FOR CHILD PATIENTS

Mother's Name: _______________________ Phone: _____________________ Employer: _________________

Father's Name: ________________________ Phone: _____________________ Employer: _________________