



## PLEASE PRINT AND COMPLETE ALL ENTRIES

Patient Name (Last, First, MI)	Date of Birth / /	Age	Marital Status ODL Number
Address (Street - City - State - Zip) Apt. No.	Home Phone ( )	Work Phone - May we call you at work? ( ) <input type="checkbox"/> Yes <input type="checkbox"/> No	
	E-Mail		
How long at this address?	Do you <input type="checkbox"/> own or <input type="checkbox"/> rent?		
If Less than 2 years, Previous Address			

Employer Name	Occupation	Social Security No.
Employer Address (Street - City - State - Zip)		Your Cell/Pager ( )

How long at this job?	If less then 2 years, Previous Employer:
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Spouse's Name (Last, First, MI)	DOB / /	Social Security No.	Spouse's Work Phone ( )
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If Minor: Parent's Name (Last, First, MI)	DOB / /	Social Security No.	Home Phone ( )
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Nearest friend or relative not living with you	Address (Street - City - State - Zip)	Home Phone ( )
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Emergency Contact	Relationship	Phone ( )
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Who is financially responsible for this bill?

How will the bill be paid today?      Cash    Check    Visa    MC    Discover    AMEX

### INSURANCE INFORMATION

Primary Insurance Name	Address (Street - City - State - Zip)	Phone ( )
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Name of Insured	Relationship	Social Security / ID No.	Group No.
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Secondary Insurance Name	Address (Street - City - State - Zip)	Phone ( )
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Name of Insured	Relationship	Social Security / ID No.	Group No.
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How did you hear about us? \_\_\_\_\_

I authorize Tualatin Dental Care to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and direct my insurance company to pay directly to the dentist or dental group, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature \_\_\_\_\_

Date \_\_\_\_\_