3033 Marina Bay Drive. #230 ● League City, TX 77573 ● (281) 334-4944

PATIENT INFORMATION

Please Circle **Title:** Dr. Mr. Mrs. Miss **Name:** ______________________________
First M Last

I prefer to be called: ____________ ☐ Male ☐ Female Birthdate: ________ Age: _____
SSN # ____________ Marital Status: S M D W DL # ______________

Home Address ______________________________
City/State ______________ Zip ________ Home Phone __________
Employer ______________________ Work Phone __________
Email Address ____________________ Cell Phone __________
How may we reach you?: Home _____ Work _____ Email _____ Cell ______
Whom may we thank for this referral? ____________________
Nearest relative *not* living with you ______________ relationship ________ Phone # ________

Guarantor (if not same as above) – Please note: we cannot bill a non-custodial parent
Name ____________________ Relationship ____________________
Birth Date ______________ SSN# ______________ Driver's License __________
Billing Address ____________________ City __________ State ____ Zip ______
Home Phone ______________ Employer ____________ Work Phone __________
May we call you at work? ________

Other Family Members

Name	Relationship	Employer/School	Work Phone

Insurance	**Primary**	**Secondary**
Insurance Co. Name		
Billing Address		
Telephone		
Group #		
Policyholder's Name		
Policyholder's SS#		
Relationship to Patient		
Policyholder's Birthdate		
Policyholder's Employer		

I hereby authorize Dr. Tieken to furnish information to insurance carriers concerning my dental condition and treatments and I hereby assign to them all payments for dental services to myself or my dependents. I understand that I am responsible for all fees regardless of insurance coverage.

Policyholder Signature ______________________________ Date ________________