Tsar Dental Excellence

PATIENT INFORMATION

Patient Name: first _____ last _____

Address _____ City _____ State _____

Zip_____ Birthdate_____ Age _____ Gender: F M

I prefer to be called: Mr. Mrs. Miss. Other _____

Patient SS: (optional _____ Marital status: single married divorced student

Occupation: _____ Employer: _____

If patient is a minor, Give parent or guardian's name: _____

Contact Information

Phone Numbers: Home: _____ Work: _____ Cell: _____

Email: _____

Can we text you? YES NO Can we call? YES NO

Preferred contact method: Home Cell text work email Best time to reach you? AM PM

Preferred Appointment Times: Mon Tues Wed Thurs Fri AM PM

In Case Of Emergency, Please Contact

Name _____ Relationship _____

Home Phone _____ Cell Phone _____ Work Phone _____

Best Phone Number To Contact Them? Home cell work

Whom May We Thank For Referring You? Family/Friend/Other _____

patient/guardian signature _____

Date _____

Do You Have A Dental insurance Plan? YES NO If you do, sign below

Assignment And Release

I certify that I (or my dependent) have insurance coverage and that assignment of benefit will be payable to Dr. Tsar for services rendered. I understand that I am financially responsible for all charges.
I authorize the doctor to release all information necessary to secure the payment of benefits.
I authorize the use of this signature on all insurance submissions.

Responsible Party Signature_____Date_____

Relationship to minor (if applicable)_____

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