

Tietan Dental Team  
1602 Penny Lane  
Walla Walla WA 99362  
(509)522-0940  
[tdental@pocketinet.com](mailto:tdental@pocketinet.com)

## Patient Information

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip

HM phone \_\_\_\_\_ WK phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Birthdate \_\_\_\_\_

SS# \_\_\_\_\_ E-mail Address \_\_\_\_\_ to confirm appointments

etc \_\_\_\_\_ Whom may we thank for referring you to our office? \_\_\_\_\_

## Responsible Party/Spouse Information

Name \_\_\_\_\_  
Last First Middle Marital Status

Residence \_\_\_\_\_  
Street City State Zip

Mailing Address \_\_\_\_\_  
Street City State Zip

HM Phone \_\_\_\_\_ WK Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Social Security# \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Number yrs employed \_\_\_\_\_

***Please provide receptionist with your dental insurance card  
or complete the following section***

### PRIM INS INFORMATION

### SECOND INS INFORMATION

Employee Name \_\_\_\_\_

Insurance Co \_\_\_\_\_

Insurance Co Address \_\_\_\_\_

(800) \_\_\_\_\_ SS# \_\_\_\_\_ Gp# \_\_\_\_\_ (800) \_\_\_\_\_ SS# \_\_\_\_\_ Gp# \_\_\_\_\_

### PLEASE SIGN:

I authorize release of any information relating to claims.  
I understand that I am responsible for all costs of  
dental treatment and where appropriate, credit bureau  
reports may be obtained.

\_\_\_\_\_  
Signed by patient or parent if minor Date

### IF INSURED, PLEASE SIGN:

I hereby authorize payment directly to Tietan Dental  
Team

\_\_\_\_\_  
Signed by insured person Date