Tietan Dental Team
1602 Penny Lane
Walla Walla WA 99362
(509)522-0940
tdentalt@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