6918 W. Military Drive
San Antonio, Texas 78227
Phone: (210) 674-3700
Fax: (210) 674-3738

Name: ____________________________ Hm Phone: ____________________Wk: Phone:____________________

Cell Phone: ____________________________ email address: ______________________________________

Social Security #:_______________________________ Date of Birth:____________________________

Home Address: _____________________________________ City: __________ Zip Code:__________________

Spouse's Name:______________________________________ Wk Phone:_________________________________

Nearest relative not living with you: __________________________________ Phone: _______________________

Nearest friend not living with you: ____________________________________ Phone: ______________________

Physician: ___________________________________ Phone: _______________________________

Landlord: ___________________________________ Phone: _______________________________

Whom may we contact in case of an emergency?

Name: ____ Phone: ________________________________

Whom may we thank for referring you to us?

Name: ____ Phone: _________________________________

Responsible party for this account: Name: ____ DOB___/___/___

Address:____ SS#: ________________________

Home #:__________________________ Wk. #:__________________________ Cell #:________________________

Insurance Co.:____________________________ Group #:________________ Ph. #:__________________________

Address: ____ State__________ Zip Code:_____________________

I authorize payment of dental benefits by my insurance provider to be paid directly to Tran Dental P.C.

Signature: ____ Date: ____________________

Please note: We do note file secondary insurance but, will provide you with the necessary forms for reimbursement.

I understand and agree I am ultimately responsible for the balance of my account. I certify that the information I have provided is true & correct. Payment is expected at the time of service unless prior arrangements have been made. Accounts 30 days past due are subject to a $25.00 late fee and will be turned over for collection after 60 days.

Signature: ____ Date: ___________________________