

PERSONAL HISTORY (Confidential)

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
First Middle Last Preferred

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

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Pager/Cell Phone \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Texas Driver's License \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Marital Status Single \_\_\_\_\_ Married \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Did someone refer you to our office? If so, whom may we thank? \_\_\_\_\_

E-Mail Address \_\_\_\_\_

FINANCIALLY RESPONSIBLE PERSON  
(If Other Than Patient)

Responsible Person \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

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

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Pager/Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Marital Status Single \_\_\_\_\_ Married \_\_\_\_\_ Spouse's Name \_\_\_\_\_

EMERGENCY CONTACT INFORMATION

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Daytime Phone \_\_\_\_\_ Pager/Cell Phone \_\_\_\_\_ Nighttime Phone \_\_\_\_\_

DENTAL INSURANCE INFORMATION

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

Social Security # \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Insurance Co. \_\_\_\_\_ Phone \_\_\_\_\_ Group Policy # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

By signing below, I authorize the release of information regarding my treatment to my insurance company. I also authorize the payment of benefits directly to Juli Powell & Ada Tiller, DDS, PC.

The information presented above is true and correct to the best of my knowledge. I understand should my insurance company not pay for my claims within 45 days of filing I will be asked to pay the balance and follow-up with my Insurance company. I further understand I am responsible for all costs of dental treatment.

Patient (or Legal Guardian) Signature \_\_\_\_\_