Tyrer Dental Care
Patient Information

Today's date: ____/____/______

Patient's last name : ____________________ First: ____________________ Middle: ___________

Marital status: ___________________ □ Mr. □ Mrs. □ Miss □ Ms. Sex: □ M □ F

Social Security #: _____-_____-______ Birth date: ________________ Age: __________

Driver's License #: _____________________________ Expiration date: __________________

Mailing address: ____

City: _______________________________ State: _______________ ZIP Code: ______________

□ Own □ Rent How long at this address: ________________

Previous address (if less than 3 years): ______________________________ State: ________ ZIP: ____________

Email address: _______________________________________ Home Phone #: (_____) ______-________

Cell Phone #: (_____) ______-________ Work Phone #: (_____) ______-________

Occupation: ___________________________ Employer: _________________________ Years employed:______

HOW DID YOU LEARN ABOUT OUR OFFICE? (Please be specific!)

□ Family □ Friend □ Internet Yellow pages □ Other □ Please specify: ____________

If patient is a minor, give parent or guardian's name: ____________________ Relationship: _____________

Spouse's name: ______________________ Spouse's employer: ________________ Years employed: _______

Spouse's birth date: ____________ Spouse's SS #: _____-_____-_____ Spouse's phone #: (____) ____-________

Insurance Information (Please give card to front desk)

Policy holder's name: ____________________________________ Birth date: ______________

Home Phone #: (_____) ______-________ Address (if different): _________________________________

Social Security #: _____-_____-______ Patient's Relationship to policy holder: ____________________

Policy holder's employer: ____________________________ Employer's phone #: (_____) ______-________

Insurance Company: ________________________ Insurance address: __________________________________

Insurance Phone #: (_____) ______-________ Policy #: _____________________ Group #: _______________

Parent or guardian (If patient is under 18)

Name: ________________________________ Relationship to patient: ________________________

Social Security #: _____-______-______ Home phone #: (_____)______-_________

Work Phone #: (_____)______-________ Cell phone #: (_____)______-_________

Driver's License #: _____________________________ Expiration: _____________________

Birth date: ____________________ Email address: ________________________________

Mailing Address: ____________________________________ City: ________________________

State: _____________ ZIP Code: ___________ How long at this address: _________________

Previous address (if less than 3 years): ___________________________ State: ________ ZIP: _______

Occupation: ______________________ Employer: ______________________ Years Employed: _____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): ____________________________________

Relationship to patient: ________________________ Home Phone #: (_____) _______-_______

Work Phone #: (_____) _______- _________ Address: ________________________________

City: __________________ State: ___________ ZIP: ____________

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Tyrer Dental Care or insurance company to release any information required to process my claims.

Patient/Guardian Signature: ____

Date: ______________________