Dr. Dustin VanTassell DDS

(Please Print Legibly)

Date: _____

Personal Information

Name: _____ SS #: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Work) _____

(Cell) _____ e-mail: _____

Birth date: _____ Sex: _____ Marital Status: _____ Spouse Name: _____

Occupation: _____ Referred by: _____

Person Responsible for Account

Name: _____ Relationship: _____ SS #: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Work) _____

Dental Insurance Information

Primary Insurance Co: _____

Insurance Co. Address: _____

Employee: _____ Relationship: _____ S.S. #: _____

Employer: _____ Policy #: _____

Secondary Insurance Co: _____

Insurance Co. Address: _____

Employee: _____ Relationship: _____ S.S. #: _____

Employer: _____ Policy #: _____

I understand that payment is my obligation regardless of insurance or any other third-party involvement.

_____ _____

PATIENT'S NAME **DATE**