Vince Tiller Dentistry
VINCENT TILLER, DDS
707 BLUFF CITY HWY
BRISTOL, TN 37620

PATIENT INFORMATION:

Patient Name:____________________________________ Date of Birth:______________ SSN_______________

Address:_______________________________________ City__________________ State____ Zip_____________

Home Phone (   ) ______-_______ Work Phone (   ) ______-________ Cell Phone (   ) ______-__________

Place of Employment (or School)_______________________________ Email _____________________________

INSURANCE INFORMATION:

Primary Insurance Policy Holder:	Secondary Insurance Policy Holder:
Employee Name:________________________	Employee Name:______________________
SSN_____________ Date of Birth__________	SSN_____________ Date of Birth________
Relationship to Patient:___________________	Relationship to Patient:___________________
Employer:_____________________________	Employer:_____________________________
Insurance Co.__________________________	Insurance Co.__________________________
Policy Number:________________________	Policy Number:________________________
Plan Number: _________________________	Plan Number: _________________________

How did you hear about our office: ( ) Phone Book ( ) Personal Recommendation ( ) Other

Whom may we thank for referring you to our office:____

To reduce our administrative costs and keep our fees to you as low as possible.

We ask that you pay your co-payment or full payment at the time you receive treatment.

Payment Options:

☐ Cash or Check ☐ Visa/MasterCard/ American Express ☐ Outside Dental Financing

SIGNATURE OF RESPONSIBLE PARTY:

X____ Date_________________

SSN:__________________________