Tran Dental P.C.

Gentle Family Dentistry

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

8647 Wurzbach Rd Suite A
San Antonio, Texas 78240
(210) 690-9430
Fax: (210) 690-2919

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: _____