Jefferson Dental
W.S. Tipton, D.D.S.
1205 George Ave.
Jefferson City, TN 37760

Patient Information

Name: _____ Social Security #_____

Home Phone (__) _____ Cell Phone (__)_____ E-mail: _____

Address: _____State: _____ Zip:_____

Sex: M ___ F ___ Birth date:_____ Marital Status:_____ Former Dentist:_____

Patient Employer/School:_____ Occupation:_____

Spouse Name:_____ How did you hear about us?_____

Emergency contact: _____ Relationship:_____ Phone: (__)_____

Primary Insurance/Guarantor

Person Responsible for Account: _____ Relation to patient: _____

Birth date: _____ Address: (if different from patient)_____

Insured Employer: _____ Occupation:_____

Business Address:_____ Business Phone: (___)_____

Subscriber #:_____ Soc. Sec #/ ID #:_____

Insurance Company: _____ Group #:_____

Additional Insurance (if applicable)

Subscriber Name:_____ Birth date:_____ Relation to patient:_____

Address: (if different from patient) _____ State:_____ Zip:_____

Phone: (__) _____ Subscriber Employer:_____ Business Phone: (__)_____

Insurance Company: _____ Group#:_____ Subscriber#:_____

Assignment and Release

I verify that I, and/or my dependents(s), have Insurance Coverage with _____ and assign directly to W.S. Tipton, D.D.S. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance information, The above named physician my use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for services.

Signature of patient/parent:_____ Date:_____

Please print name of patient/guarantor: _____ Relation to patient:_____