PAUL B. TAN, D.M.D.

GENERAL & COSMETIC DENTISTRY

• EST. 1989 •

Patient Information

Name ______________________ Home phone ______________________

Address ______________________ Work Phone ______________________

City ______________ State ______ Cell Phone ______________________

Zip ______________________ E-mail ______________________

SS# ______________________ Birth Date ______________________

☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced

Whom may we thank for referring you? ______________________________________

Emergency contact ______________________ Phone number ______________________

Responsible Party

Are you the person financially responsible for this account? Yes ❑ No ❑

Driver's license # of person financially responsible for this account: ______________________

Insurance Information

Name of employer ____

Insurance company ______________________________ Group # ______________

Address ______________________ City ______________ St. ______ Zip ________

Phone Number ______________________ Are you the primary holder on the above insurance? Yes ❑ No ❑

If No, what is the name of the Primary holder______________________ Primary's Birth date ____________

SS # of the Primary holder______________________

Do you have additional dental insurance? __________ Insurance company ______________________

Address ______________________ City ______________ St. ______ Zip ________

X ____ ______________________

Signature of Patient or Parent/Guardian if minor **Date**

100 BUSH STREET AT BATTERY, SUITE Nº.1475 SAN FRANCISCO, CA 94104 TELEPHONE : 415.438.7929 FACSIMILE : 415.438.7926