Tiger Town Dental Care

Thunga Nguyen, DDS

8160 YMCA Plaza Drive, Ste. B - Baton Rouge, Louisiana 70810 - (225)768-8200

Patient Information:

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name: _____ Patient is: ___ Policy Holder ___ Responsible Party ___ Minor

Address: _____ ***Apartment /Unit number***: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Work Phone: _____ Cellular Phone: _____ Email: _____

Sex: ___ Male ___ Female Marital Status: ___ Married ___Single ___ Divorced ___ Separated ___ Widowed

Date of Birth: _____ Social Security No.: _____ Driver's License No.: _____

Employment Status: ___ Full Time ___ Part-time ___ Retired Student Status: ___ Full Time ___ Part-time

Employer:_____ Employer Address/Phone Number: _____

Who to contact in case of emergency: _____ Relationship: _____ Phone: _____

Former Dentist: _____ City/State:_____ Date of last Dental visit: _____

Did someone refer you to our practice? If so, whom can we thank for your referral? _____

Responsible Party (if someone other than the patient)

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ *Apartment/Unit Number:* _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Work Phone: _____ Cellular Phone: _____ Pager: _____

Date of Birth: _____ Social Security No.: _____ Driver's License No.: _____

Employer: _____ Employer Address/Phone Number: _____

Primary Insurance Information:

Name of Insured: _____ Relationship to Patient: ___ Self ___ Spouse ___Parent ___ Other

Insured's Social Security No.: _____ Enrollee/Member No.: _____ Insured's Date of Birth: _____

Employer: _____ Insurance Company: _____

Employer Address: _____ Insurance Company Address: _____

City, State, Zip: _____ City, State, Zip: _____

I understand that this office files my insurance as a courtesy and that the amount estimated to be covered by my insurance company is only an estimate as determined by information given by me and my insurance company and that I am responsible for any charges left unpaid by my insurance company.

Patient Signature: _____ Today's Date: _____

Responsible Party **Signature: _____ Today's Date: _____**