BROBERG & TIEKEN
DENTAL

9521 US Hwy 290 West, Suite 103 ● Austin, TX 78737 ● (512) 888-9453

PATIENT INFORMATION

Please Circle **Title:** Dr. Mr. Mrs. Miss **Name:** _____
First M Last

I prefer to be called: _____ □ Male □ Female Birthdate: _____ Age: _____
SSN # _____ Marital Status: S M D W

Home Address _____
City/State _____ Zip _____ Home Phone _____
Employer _____ Work Phone _____
Email Address _____ Cell Phone_____
How may we reach you? Home _____ Work _____ Email _____ Cell _____
Whom may we thank for this referral? _____
Nearest relative *not* living with you _____relationship _____ Phone # _____

Guarantor (if not same as above) – Please note: we cannot bill a non-custodial parent
Name _____ Relationship _____
Birth Date _____ SSN# _____
Billing Address _____ City _____ State ____ Zip _____
Home Phone _____ Employer _____ Work Phone _____
May we call you at work? _____

Other Family Members (optional)

Name	Relationship	Employer/School	Work Phone

Insurance	**Primary**	**Secondary**
Insurance Co. Name		
Billing Address		
Telephone		
Group #		
Policyholder's Name		
Policyholder's SS#		
Relationship to Patient		
Policyholder's Birthdate		
Policyholder's Employer		

I hereby authorize Dr. Broberg to furnish information to insurance carriers concerning my dental condition and treatments and I hereby assign to them all payments for dental services to myself or my dependents. I understand that I am responsible for all fees regardless of insurance coverage.

Policyholder Signature _____ Date _____