WELCOME! Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available in the most comfortable setting possible. If you have and questions, please do not hesitate to ask.

TRISTAN GALLOWAY, DDS
Your Neighborhood Family Dentist

Today's Date:_____

PATIENT INFORMATION:

Last Name:_____ First Name:_____ MI:_____
Preferred Name:_____ ☐ Male ☐ Female

Email:_____

☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Birth Date:_____ SS#:_____

Main Phone #:_____ Text Message: ☐ Yes or ☐ No
Secondary Phone#:_____ Text Message: ☐ Yes or ☐ No

Address:_____ Employer:_____

City:_____ State:_____ Zip:_____ Employer Phone: _____

Person to contact in case of emergency:_____ Phone#:_____

Whom may we thank for referring you?_____

RESPONSIBLE PARTY:

Are you the responsible party? ☐ Yes ☐ No (Please fill out their information)

Last Name:_____ First Name:_____ MI_____

Preferred Name:_____ Relationship to Patient:_____

Birth Date:_____ SS#:_____ Main Phone#:_____

Address:_____ Employer:_____

City:_____ State:_____ Zip:_____ Employer Phone:_____

Current Patient in our Office? ☐ Yes ☐ No

INSURANCE INFORMATION:

Insurance Company:_____ Employer:_____

Subscriber ID:_____ Group#:_____

Name of Insured:_____ Date if Birth:_____

Relationship to Patient:_____

ADDITIONAL INSURANCE? ☐ Yes ☐ No If yes, please let the front desk know this information.

AUTHORIZATION AND RELEASE:

I certify that I and/or my dependent has insurance coverage with the above-named insurance and assign directly to Tristan Galloway, DDS 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 insurance. I authorize the use of my signature on all insurance submissions. Dr. Galloway may use my healthcare information and may disclose such information to the above-named insurance and their agents for the purpose of obtaining payment of services and determining insurance benefits or the benefits payable related services.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please Print Name of Person Signing Date