****Please fill out BOTH sides of this form COMPLETELY and bring it with you to your consultation appointment.**** **A B C**

SWENSON
ORTHODONTICS

CONFIDENTIAL **RESPONSIBLE PARTY** INFORMATION

Name_____ Marital Status_____
Last First Middle

Residence_____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone#_____Cell#_____Work#_____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to patient _____

Employer _____Occupation _____ # Years Employed _____

Spouse's Name _____Relationship to patient _____
Last First Middle

Employer _____Occupation _____ # Years Employed _____

Social Security # _____ Birthdate _____Cell # _____ Work #_____

CONFIDENTIAL **PATIENT** INFORMATION

Patient's Name _____ Nickname_____
Last First Middle

Male / Female Age_____ Birthdate _____ Home Phone #_____

Address_____
Street City State Zip

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

DENTAL INSURANCE INFORMATION

Policy Holder's Name_____Social Security#_____Birthdate _____

Insurance Company _____Group # _____ ID # _____

Insurance Co. Address _____

Insurance Co. Phone #_____Policy Holder's Employer _____

Do you have dual coverage? No ____ Yes ____

Policy Holder's Name_____Social Security#_____Birthdate _____

Insurance Company _____Group # _____ ID # _____

Insurance Co. Address _____

Insurance Co. Phone #_____Policy Holder's Employer _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if patient is a minor) _____

Updates (date & initial) _____

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