SWENSON
ORTHODONTICS

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

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

Name _____ (Last / First / Middle) Marital Status _____

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 _____ (Last / First / Middle) Relationship to patient _____

Employer _____ Occupation _____ # Years Employed _____

Social Security # _____ Birthdate _____ Cell# _____ Work# _____

CONFIDENTIAL PATIENT INFORMATION

Patient's Name _____ (Last / First / Middle) Nickname _____

(•) 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) _____

220 North 1200 East, Suite 202
Lehi, Utah 84043
Phone: 801-766-5500
Fax: 801-766-5605

swensonsmiles.com

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