HANSEN DENTISTRY

Patient Information

Patient Name: _____ Preferred Name: _____
First MI Last
Male Female Married Single Child Other _____
Soc. Sec. #: _____ DOB: _____ Drivers. Lic. #_____
Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____
E-mail: _____ I would like email correspondence Y/N
Home Address:

_____
Street Apartment #

_____
City State Zip Code
Employer Name: _____ Position: _____
Please list any family members who are patients in our office:

_____

Referral Information

May we thank someone for referring you? Or did you find us on your own? How?

Date of Last Dental Visit: _____ Date of Last Dental rays:_____
Name and Phone number of previous dentist:

_____

For what reason do you come to our office today?

_____

If you could improve your smile, what would you change?

_____

Insurance Information

Name of Insured: _____ Is insured a patient? Yes No
Last First MI
Insured's Social Security #: _____ Birth Date: _____ Group #: _____
Insured's Employer Name: _____
Patient's relationship to insured: Self Spouse Child Other _____
Dental insurance company name: _____

If you have insurance, we will accept your coverage as a form of payment. You are responsible for deductibles, co-payments, and any balances that may not be covered by your insurance company at the time of service.

I grant my permission to telephone me at home _Yes/No_ (circle) and at work _Yes/No_ (circle) to discuss matters related to this form. If you would like us to file your insurance claim, please initial below to authorize the release of information necessary to process your claim and collect payment._____ Initials

I agree to have any photos taken of me to be used for education, training and/or marketing.

I have read the above conditions and agree to their content.

Patient's Name_____Responsible Party _____

Signature of guarantor_____Relationship to Patient _____ Date _____