THE SMILE RANCH ORTHODONTICS

BY ALAN C. JENSEN DDS MS

★ PATIENT INFORMATION ★

WELCOME TO OUR OFFICE: So that we might become better acquainted, please complete this entire form.

Date _____ Email _____

Patient's Name _____
LAST FIRST MIDDLE

Address _____
STREET CITY STATE ZIP

Home Phone _____ Birthday _____ Social Security # _____

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

★ 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 _____ Work Phone _____

Previous Address (if less than 3 years) _____
STREET CITY STATE ZIP

Social Security # _____ Birthday _____ Relationship to Patient _____

Employer _____ Occupation _____ Years Employed _____

Spouse's Name _____ Relationship to Patient _____
LAST FIRST MIDDLE

Spouse's Employer _____ Occupation _____ Years Employed _____

Work Phone _____ Social Security # _____ Birthday _____

★ INSURANCE INFORMATION ★

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ ID # _____ Local No _____

Do you have dual coverage? Yes ____ No ____ If Yes:

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ ID # _____ Local No _____

Insured's Employer _____

★ EMERGENCY INFORMATION ★

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship to Patient _____

★ CREDIT REPORT AUTHORIZATION ★

I am interested in a payment plan for orthodontic treatment. I understand that a credit bureau report will be obtained.

Signature (Parent Signature if Minor) _____ Date _____

Confidential (for record and pre-treatment evaluation) **Thank you for supplying the above information**