A B C

Patient Information

Patient's Name:____
Last First Middle

Address:____
Street City State Zip

Date of Birth:__________Social Security#:_______________Name of School:____________________Grade:_____

Home Phone:____________________Cell Phone:_______________________ Work Phone: _____________________

Who may we thank for referring you to our office?____

Name of General Dentist? _______________ Date of **Last** Cleaning? ________ Date of **Next** Cleaning? _________

If patient is a minor, provide the parent or guardian's name: ____

Patient's Email:________________________________Responsible Party Email: ____________________________

Responsible Party Information

Name:____
Last First Middle

Social Security#:___________________Birth Date:________________Relationship to Patient:_________________

Employer:_____________________________Occupation:_________________________No. Years Employed:______

Residence:____
Street City State Zip

How long at this address:__________Home/Cell Phone:_______________________Work Phone:______________

Previous Address (if less than 3 years):____
Street City State Zip

Spouse's Name:____Relationship to Patient:_________________
Last First Middle Initial

Spouse's Employer:_____________________Occupation:__________________No. Years Employed:____________

Spouse's Social Security#:____________________________ Spouse's Birth Date:___________________________

Insurance Information

Insured's Name:____DOB:____________________________

Insured's Soc. Sec. #:____________________ Group#___________________Member ID#______________________

Insurance Company:____Insured's Employer: ____________________

Insurance Co. Address:_____________________________________ Insurance Phone #: _____________________

Revised Sept 2014

Jensen
ORTHODONTIC ARTS

Insurance Information Continued

Do you have dual coverage? ☐ Yes ☐ No ***If YES***, please continue:

Insured's Name:____DOB:_______________________

Insured's Soc. Sec. #:_________________ Group#________________Member ID#__________________

Insurance Company:__________________________________Insured's Employer: _________________

Insurance Co. Address:_______________________________ Insurance Phone #: __________________

Emergency Contact Information

Name of nearest relative not living with you:____
Last First Middle Initial

Complete Address:____
Street City State Zip

Phone Number:_________________________________Relationship to Patient:____________________

Consent (Circle ***does*** or ***does not*** AND initial all 3 items)

_____Dr. Jensen and/or his staff ***does/does not*** have my permission to communicate with other dentists, physicians, laboratory technicians, or health care providers regarding diagnosis, treatment planning, or treatment.

_____Dr. Jensen and/or his staff ***does/does not*** have my permission to leave a message regarding my child's treatment on my answering machine.

_____Dr. Jensen and/or his staff ***does/does not*** have my permission for any photographs, x-rays, or study models to be used for advertisements, scientific meetings, presentations, and publications of a scientific nature or for study group purposes to further the art and science of orthodontics. It is understood that the patient will not be identified by name other than for medical records purposes.

The information within this document is accurate and complete to the best of my knowledge.

Signature (Parent's signature, if minor) _______________________________________Date:__________________

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