



**SWANSON**

**Dental Associates**

**PATIENT INFORMATION (please print)**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_  
Last First MI

Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M/F

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Numbers: Home (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

E-mail address: \_\_\_\_\_

**WHAT IS THE BEST WAY(S) TO CONTACT YOU TO CONFIRM OR SCHEDULE APPOINTMENTS?**

- E-mail     Home     Work     Cell phone

Who can we thank for referring you to our office? \_\_\_\_\_

In case of emergency, whom should we contact? \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Is Patient a Minor?    YES     NO    If yes, please fill in information below.

**Patient/Guardian Information:**

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ zip: \_\_\_\_\_

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

**DO YOU HAVE DENTAL INSURANCE?    YES     NO    IF YES, PLEASE PROVIDE US WITH YOUR INFORMATION BELOW**

**PRIMARY DENTAL INSURANCE**

Name of Subscriber: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

SS # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ or ID# \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Co: \_\_\_\_\_

Group #: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone number: (\_\_\_\_) \_\_\_\_\_

**SECONDARY DENTAL INSURANCE**

Name of Subscriber: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

SS # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ or ID# \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Co: \_\_\_\_\_

Group #: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone number: (\_\_\_\_) \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I hereby authorize payment directly to Swanson Dental Associates for all insurance benefits otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents I authorize the above dentist and or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_