Patient Information

CHILD'S Name_____ Sex: M____ F____

Home Address_____ City_____ Zip_____

Home Phone_____ Birthdate_____ Social Security #_____

Cell Phone_____ E-mail_____

Whom may we thank for referring you?_____

MOTHER'S Name_____ Birthdate_____

Address_____ City_____ Zip_____

Phone_____ Social Security #_____

Employer_____ Work #_____ Cell #_____

FATHER'S Name_____ Birthdate_____

Address_____ City_____ Zip_____

Phone_____ Social Security #_____

Employer_____ Work #_____ Cell #_____

Person to call in case of emergency:_____
Home Phone #_____ Work #_____ Cell #_____
Does your child have dental insurance? Yes____ No____
Name of Subscriber_____

Relationship_____ Resides with _____ %

Social Security #_____ Birthdate_____

Employer_____ Insurance Company_____ Group #_____
Does your child have any co-insurance? Yes____ No____
Name of Subscriber_____

Relationship_____ Resides with _____ %

Social Security #_____ Birthdate_____

Employer_____ Insurance Company_____ Group #_____

Do you have Medi-cal? Yes_____ No_____
I authorize any necessary x-rays and treatment deemed advisable by Dr. Swanson.
I understand that I am the responsible parent and agree to pay the account at the time of treatment.

Signature_____ **Date**_____