Patient Information

Patient's Name_____ **Sex:** M____ F____

Home Address_____ City_____ Zip_____

Home Phone_____ Cell Phone_____ Single____ Married____

Birthdate_____ Social Security #_____ Drivers License #_____

Employer_____ Work Phone_____

E-mail_____

Whom may we thank for referring you?_____

_____

Spouse's Name_____ **Sex:** M____ F____

Address_____ City_____ Zip_____

Birthdate_____ Home Phone_____ Cell Phone_____

Social Security #_____

Employer_____ Work Phone_____

_____

Nearest relative not living with you_____

Home Phone #_____ **Work Phone #**_____

_____

Do you have dental insurance? Yes_____ No_____

Name of Subscriber_____

Name of insurance company_____ Group #_____

Address_____ City_____ State____ Zip_____

Do you have any co-insurance? Yes_____ No_____

Name of Subscriber_____

Name of insurance company_____ Group #_____

Address_____ City_____ State____ Zip_____

Do you have Medi-cal? Yes_____ No_____

I authorize any necessary x-rays and treatment deemed advisable by Dr. Swanson.

Signature_____ **Date**_____