Swenson Orthodontics

Steven J Swenson, DDS MS
408 West 39th Street, Suite 2
Kearney Ne 68845
308-234-9226

PATIENT:

Patient Name_____Nickname _____Age_____Gender M F
Mailing Address_____ City_____ St_____Zip_____
School _____ Favorite Activities _____
Birth date_____ Phone #_____

PARENTS/GUARDIANS INFORMATION (FILL IN BOTH SIDES COMPLETELY IF PARENTS LIVE AT DIFFERENT ADDRESSES):

Dad/Guardian's name_____
Relationship to patient _____
Address _____
City/St/Zip_____
Phone #_____
Occupation_____

Mom/Guardian's name_____
Relationship to patient _____
Address_____
City/St/Zip_____
Phone #_____
Occupation_____

Person responsible for payment of services_____ Social Security # _____

Who is your family dentist? _____Person who referred you to us?_____

DENTAL INSURANCE INFORMATION: PLEASE COMPLETE AS MUCH AS POSSIBLE

Name of Subscriber_____ Relationship to Patient_____
Birth date_____ Social Security Number_____Date Employed_____Work Phone_____
Name of Employer_____Insurance Company_____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Subscriber_____Relationship to Patient_____
Birth date_____ Social Security Number_____Date Employed_____Work Phone_____
Name of Employer_____Insurance Company_____

IF YOU HAVE INSURANCE PLEASE SIGN:

I herby authorize and direct payment of the dental benefits otherwise payable to me, directly to Dr. Steven Swenson, D.D.S., M.S., L.L.C.

X _____
Subscriber Signature Date

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating orthodontist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim

X _____
Signature Date