

Date: _____

GUENTHNER, LARSON AND HILL ORTHODONTICS

NAME: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Patient's Birthdate: _____ Social Security #: _____

Present Employer: _____ Phone: _____

Employers Address: _____ Yrs there: _____

Position: _____

Spouse's Name: _____

Present Employer: _____ Phone: _____

Employers Address: _____ Yrs there: _____

Birthdate: _____ Social Security #: _____

Position: _____

INSURANCE INFORMATION

Primary Orthodontic Insurance: _____

Group Number: _____ Policy Number: _____

Address of Insurance Company: _____

Name of Policy Holder: _____

Secondary Orthodontic Insurance _____

Group Number: _____ Policy Number: _____

Address of Insurance Company: _____

Name of Policy Holder: _____

Family Dentist Name: _____ City: _____

Referring you? YES or NO

Please complete this form and bring it with you to your first office visit.