

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

## GUENTHNER, LARSON AND KIM 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.