Guenthner, Larson, & Kim Orthodontics

Date: ___________________

Patient Information

Name (Last, First, Middle): ____

Street Address: ____

City: ___________________________ State: ______ Zip: __________ Phone: _________________

Date of Birth: month _________date ________year__________

Responsible Party Information

Father's Name (Last, First, Middle): ____

Street Address (if different from above): ____

City: __________________________________ State: ______ Zip: ________ Phone: ___________

Social Security Number: ____-____-____ DOB: _______________

Present Employer: ____ Work Phone: ___________

Position or Title: _____________________________________ Years there: ____________________

Married _____ Single _____ Divorced _____ E-mail address: _________________

Mother's Name (Last, First, Middle): ____

Street Address (if different from above): ____

City: __________________________________ State: ______ Zip: ________ Phone: ___________

Social Security Number: ____-____-____ DOB: _______________

Present Employer: ____ Work Phone: ___________

Position or Title: _____________________________________ Years there: ____________________

Insurance Information

Primary Orthodontic Insurance: ____

Group Number: _________________________ Policy Number: ______________________________

Address of Insurance Company: ____

Secondary Orthodontic Insurance: ____

Group Number: _________________________ Policy Number: ______________________________

Address of Insurance Company: ____

Family Dentist: Name: ______________________________ **City:** ______________________
Referring You? Yes or No

Who may we thank for referring you to our office? ___________________________________

Please complete this form and bring it (and any insurance forms) with you to your first office visit.