

**PATIENT:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_  
 Marital Status: (please circle) Single Married Divorced Widowed  
 Date of Birth: \_\_\_\_\_ Full Time Student: \_\_\_\_\_ No \_\_\_\_\_ Yes If yes, where? \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Telephone Number(home): \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Employer's Address: \_\_\_\_\_  
 Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Telephone Number(home): \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Employer's Address: \_\_\_\_\_

**PARENT INFORMATION (If patient is a minor)**

If you are not the patient or parent, please indicate your relationship: \_\_\_\_\_  
**Father's Name:** \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Telephone Number(home): \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Employer's Address: \_\_\_\_\_  
**Mother's Name:** \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Telephone Number(home): \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Employer's Address: \_\_\_\_\_

**NEAREST RELATIVE (not living with you)**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Telephone Number(home): \_\_\_\_\_ (work) \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

**INSURANCE INFORMATION**

**IN ORDER TO PROCESS YOUR INSURANCE CLAIM, ALL INFORMATION MUST BE COMPLETED BELOW**

	PRIMARY DENTAL INS.	SECONDARY DENTAL INS.
Name of Insurance Company	_____	_____
Name of Employee	_____	_____
Employee's SSN	_____	_____
Employee's Birth Date	_____	_____
Name of Employer	_____	_____
Employee's Group Number	_____	_____
Insurance Phone Number	_____	_____

**AUTHORIZATION**

I hereby authorize Paul L. Christianson DDS PA to administer such medications and perform such diagnostic and therapeutic procedure as may be necessary for proper dental care. The information on this page and Medical History for are correct to the best of my knowledge.

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