Patient Information

Date _____

Patient's Name _____ [M F]
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____

Father's Name _____ Mother's Name _____

Parents are: Married, Divorced, Separated, Single, Foster Parent (Please circle one)

Brothers and/or sisters that have been patients here: _____

Whom may we thank for referring you to our office: _____

Responsible Party Information

Name _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

Cell Phone _____ Home Phone _____ Work Phone _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Spouse's Cell Phone _____ Spouse's Work Phone _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Do you have dual coverage? Yes ❒ No. ❒ If Yes:

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____

Medical Assistance: Yes No (Please circle one)

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship _____

I hereby authorize Dr. Jonathan Hanks and/or Dr. Benjamin Hanks to treat my child. As the parent or guardian bringing the child, I accept responsibility for full payment of treatment performed by La Crosse Pediatric Dentistry LLC.

Print Name _____

Signature (Parent's signature if minor) _____