WELCOME

Clayton M. Hansen DDS

We would like to get to know you better!

Date_____

Patient Name _____ Male ☐ Female ☐

Date of Birth _____ Age _____ Who referred you to our office? _____

Residence _____ City _____ Zip_____

E-Mail _____ Phone _____

If Child; Parent Name _____ Occupation_____ Employer _____

Wk. Address _____ City _____ Zip _____ Phone _____

Spouse's Name _____ Occupation _____ Employer_____

Wk. Address _____ City _____ Zip _____ Phone _____

In case of an emergency contact _____

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Person Responsible for Dental Investment

Name of Responsible Party _____Relationship _____

Residence Address _____City_____ Zip_____

Home Phone # _____ Social Security # ___-___-___

Date of Birth _____ Employer _____

Wk. Address _____ City _____ Zip _____ Phone _____

Patient Insurance Information

Name of Carrier _____ Name of Insured _____

Social Security # ___-___-___ Insurance ID # _____ Group # _____

Date of Birth _____ Relationship to Patient _____

Secondary Insurance Information

Name of Carrier _____ Name of Insured _____

Social Security # ___-___-___ Insurance ID # _____ Group # _____

Date of Birth _____ Relationship to Patient _____