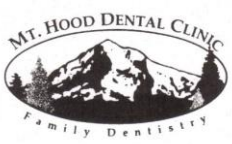

PAUL S. HANSEN, D.M.D.

PATIENT INFORMATION

Patient Name (First, MI, Last):				Date:	
Social Security Number:				Date of Birth:	
Address:				Sex:	☐ Male ☐ Female
City:		State:		Zip Code:	
Home Phone:		Work Phone:		Cell Phone:	
Employer:			Occupation:		
Employer Address:					

If someone OTHER than the patient is responsible for payment, please complete the following:

Name of responsible party:				Relationship to patient:	
Social Security Number:				Date of Birth:	
Address:					
City:		State:		Zip Code:	
Home Phone:		Work Phone:		Cell Phone:	
Employer:			Occupation:		
Employer Address:					

INSURANCE INFORMATION

PRIMARY INSURANCE			
Name of Insured:			
Social Security Number Or ID Number:		Date of Birth:	
Employer:		Group #:	
Primary Insurance Company:			
Insurance Company Address:			
Insurance Company Phone #:			

SECONDARY INSURANCE			
Name of Insured:			
Social Security Number Or ID Number:		Date of Birth:	
Employer:		Group #:	
Secondary Insurance Company:			
Insurance Company Address:			
Insurance Company Phone #:			

Emergency Contact Name:		Phone #:	

Patient/Guarantor Signature: _____ Date: _____

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