The Center For Jaw And Facial Surgery, P.C.
Jay I. Swanson, D.D.S., M.D.
Oral & Maxillofacial Surgeon

Date: _____

Patient's Name: _____ _____ _____ _____ _____ - _____ - ___ __
(Legal) Last First MI Nickname Social Security Number

Home Address: _____ Employer's Name: _____
_____ _____ _____ _____ _____ _____
City State Zip Code City State Zip Code

Home Phone #: (____) _____ - _____ Work Phone #: (____) _____ - _____ Cell Phone #: (____) _____ - _____

Driver's Lic. # _____ Marital Status (Please circle one)
Birthdate: _____ / _____ / _____ Sex: M or F Single Married Divorced Widowed Separated

Age: _____ Student's School: _____ Spouse's Name: _____

Who may we thank for referring you to us? _____

Your Dentist:
Name: _____
Address: _____
City, State, ZIP: _____
Phone #: (_____) _____ - _____

Your Physician:
Name: _____
Address: _____
City, State, ZIP: _____
Phone #: (_____) _____ - _____

Person responsible for bill if not yourself:
Name: _____
Relationship: Parent Spouse Other _____
Birthdate: _____ SS#: _____ - _____ - _____
Address: _____
City, State, ZIP: _____
Phone #: (_____) _____ - _____

Next of Kin/person to contact in emergency:
Name: _____
Relationship: Parent Spouse Other _____
Address: _____
City, State, ZIP: _____
Phone #: (_____) _____ - _____

INSURANCE INFORMATION (insurance cards required)

PRIMARY COVERAGE:

DENTAL Carrier Name: _____
Address: _____
City, State, ZIP: _____
Phone #: (_____) _____ - _____
Policy #: _____
Group # _____

MEDICAL Carrier Name: _____
Address: _____
City, State, ZIP: _____
Phone #: (_____) _____ - _____
Policy #: _____
Group#: _____

Policy Holder's Name: _____
Home Address: _____
City, State, ZIP: _____
Home Phone #: (_____) _____ - _____
Employer Name: _____
City, State, ZIP: _____
Work Phone #: (_____) _____ - _____
Birthdate: _____
Social Security #: _____ - _____ - _____
Sex (Male or Female): _____
Relationship to Patient: _____

SECONDARY COVERAGE:

DENTAL Carrier Name: _____
Address: _____
City, State, ZIP: _____
Phone #: (_____) _____ - _____
Policy #: _____
Group#: _____

MEDICAL Carrier Name: _____
Address: _____
City, State, ZIP: _____
Phone #: (_____) _____ - _____
Policy #: _____
Group #: _____

Policy Holder's Name: _____
Home Address: _____
City, State, ZIP: _____
Home Phone #: (_____) _____ - _____
Employer Name: _____
City, State, ZIP: _____
Work Phone #: (_____) _____ - _____
Birthdate: _____
Social Security #: _____ - _____ - _____
Sex (male or female): _____
Relationship to Patient: _____

Initial & date if no changes:

_____/_____ _____/_____ _____/_____ _____/_____
Initials / date Initials / date Initials / date Initials / date