PATIENT REGISTRATION

STENSVAD Dental Group
professional care · personal concern

Aaron B. Stensvad, D.M.D. P.C.
1415 SE Ankeny St Portland OR 97214
503.233.4871

Whom may we thank for referring you to our office?_____ Date_____

Patient Name_____ Birthdate _____/_____/_____ M or F
First M.I. Last (Circle)

Residence & Mailing Address_____
Street PO Box City State Zip

Social Security No._____ Employer_____

Phone Numbers:

Home_____ Cell_____

Work_____Ext._____ Email_____

Responsible Party Information

Responsible Person_____ Age_____ Birthdate _____/_____/_____ M or F
First M.I. Last (Circle)

Residence & Mailing Address_____
Street PO Box City State Zip

Relationship to Patient_____

Phone Numbers:

Home_____ Cell_____

Work_____Ext._____ Email_____

Spouse Information

Spouse Name_____ Employer_____ Work #_____Ext._____

Social Security No._____ Birthdate _____/_____/_____

Dental Insurance Information

Primary Insurance _____
Policy Holder Birthdate ID # Social Security No. Grp #

Insurance Company_____
Name of Insurance Address Phone Number

Secondary Insurance_____
Policy Holder Birthdate ID # Social Security No. Grp #

Insurance Company_____
Name of Insurance Address Phone Number

Person to contact if unable to reach you directly

Name of Friend or Relative (not living with you)_____
First M.I. Last Relationship

Residence & Mailing Address_____
Street PO Box City State Zip

Home Phone_____ Cell Phone_____

I certify that I am authorized to furnish the above information requested. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that it is my responsibility to monitor my insurance benefits and maximums. I authorize my insurance company to pay to the dentist all benefits and authorize this signature on all insurance submissions.

Signature:_____ **Date**_____