

# Welcome to Gronberg Orthodontics

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## Patient Information

Patient's Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_ - \_\_\_\_ - \_\_\_\_ or Insurance ID # \_\_\_\_\_  
How did you hear about our office? \_\_\_\_\_ Patient's Dentist \_\_\_\_\_  
Has any member of your family previously undergone Orthodontic treatment? \_\_\_\_\_  
Last Date of cleaning \_\_\_\_\_

## Responsible Party Information

**Responsible Party's Name** \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
How many years at current address? \_\_\_\_\_ Home Ph. \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Cell Ph. \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Previous Address?(if less than 3 yrs.) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
SS# \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Drivers License # \_\_\_\_\_  
Employer \_\_\_\_\_ Work Ph. \_\_\_\_ - \_\_\_\_ - \_\_\_\_ No. of years \_\_\_\_\_  
Employer address \_\_\_\_\_ Occupation \_\_\_\_\_

**Email address** \_\_\_\_\_

(Added to your confidential file for optional email confirmations, etc.)

**Father/Guardian Name** \_\_\_\_\_ **Check if same as above**   
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Ph. \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Cell Ph. \_\_\_\_ - \_\_\_\_ - \_\_\_\_ SS# \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Employer \_\_\_\_\_ Work Ph. \_\_\_\_ - \_\_\_\_ - \_\_\_\_ No. yrs \_\_\_\_\_  
Employer address \_\_\_\_\_ Occupation \_\_\_\_\_

**Mother/Guardian Name** \_\_\_\_\_ **Check if same as above**   
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Ph. \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Cell Ph. \_\_\_\_ - \_\_\_\_ - \_\_\_\_ SS# \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Employer \_\_\_\_\_ Work Ph. \_\_\_\_ - \_\_\_\_ - \_\_\_\_ No. yrs \_\_\_\_\_  
Employer address \_\_\_\_\_ Occupation \_\_\_\_\_

## Dental Insurance Information

Insured's Name \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's SS # \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Insurance Company address \_\_\_\_\_  
Insurance Company Phone # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Insured's Employer \_\_\_\_\_

Secondary Insured's Name \_\_\_\_\_ Insured's SS # \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Secondary Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_ Group \_\_\_\_\_  
Secondary Insurance Company address \_\_\_\_\_  
Secondary Insured's Employer \_\_\_\_\_

## Emergency Information

Emergency Contact (other than guardian) \_\_\_\_\_  
Relationship \_\_\_\_\_ Daytime Ph. \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Alternative Ph. \_\_\_\_ - \_\_\_\_ - \_\_\_\_

I certify that all of the above information is true and it is my responsibility to inform this office of any changes, and that in order to receive complete information on financial options it is necessary for me to authorize a credit report.

**Signature** (Guardian's signature if a minor) \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Relationship to the patient \_\_\_\_\_ A B C F N