Laurie T. Hanschu, D.D.S.
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This information is confidential and is for Dr. Hanschu's records only. Please take a few moments to answer all questions completely and accurately. There are 4 parts to this form. Thank you.

PART 1	**PATIENT INFORMATION**					
PATIENT NAME:	(FIRST)	(INITIAL)	(LAST)			
HOME ADDRESS:	(STREET)		(CITY)		(ZIP)	
EMPLOYED BY:			Occupation:			
WORK ADDRESS:	(STREET)		(CITY)		(ZIP)	
BIRTHDATE:		HOME PHONE:	( )	WORK PHONE:	( )	
E-MAIL:				CELL PHONE:	( )	
SOC. SEC #:		IF FULL TIME STUDENT, NAME OF SCHOOL:				
WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?						
INSURANCE:	(COMPANY)		(GROUP#)		(ID#)	

PART 2	**SPOUSE/PARTNER INFORMATION**				
SPOUSE'S NAME:	(FIRST)	(INITIAL)	(LAST)		
EMPLOYED BY:			OCCUPATION:		
WORK ADDRESS:	(STREET)		(CITY)		(ZIP)
WORK PHONE:	( )	CELL PHONE:	( )		
BIRTHDATE:		SOC. SEC #:			
INSURANCE:	(COMPANY)		(GROUP#)		(ID#)

PART 3	**PERSON FINANCIALLY RESPONSIBLE**				
	☐ *Check here if same as "patient" above* ☐ *Check here if same as "spouse" above*				
NAME:	(FIRST)	(INITIAL)	(LAST)		
HOME ADDRESS:	(STREET)		(CITY)		(ZIP)
EMPLOYED BY:					
WORK ADDRESS:	(STREET)		(CITY)		(ZIP)
WORK PHONE:	( )		CELL PHONE:	( )	
BIRTHDATE:		HOME PHONE:	( )		
SOC. SEC #:		HOME FAX:	( )		

PART 4	**CONSENT FOR TREATMENT OF A MINOR**

I, (parent/guardian name)_____, being the parent, guardian, or other person entitled to legal custody of (name of minor)_____, a minor child, do hereby authorize and consent to any x-rays, examination, anesthetic, or dental treatment to be rendered to said minor under the general or direct supervision of Laurie T. Hanschu, D.D.S., as Dr. Hanschu deems necessary. This authorization will remain in effect unless Dr. Hanschu is notified by the parent or guardian.

Parent/guardian signature_____Date_____