PATIENT INFORMATION

Date ______________________

Patient's Last Name____________________ First Name_______________ Middle Initial____

Prefers to be called:____

Date of Birth_________________________ Gender: Male Female

Home Address ____

City____ State______ Zip Code__________

Home Phone (______)___________________ Work Phone (______)____________________

Cell Phone (______)____________________ Cell Phone Carrier ________________________

Email____

Please send appointment reminders: Text Email

Whom may we thank for referring you to our office?____________________________________

FINANCIALLY RESPONSIBLE PARTY

Last Name________________________ First Name___________________ Middle Initial___

Social Security #_________________ Date of Birth________ Relationship to Patient_________

Home Address (if different)____

City____ State______ Zip Code__________

Home Phone (______)___________________ Work Phone (______)____________________

Cell Phone (______)____________________ Cell Phone Carrier ________________________

Email____

Employer_____________________________ Occupation_____________________________

Spouse's Last Name___________________ First Name___________________ Middle Initial___

Social Security #_________________ Date of Birth________ Relationship to Patient_________

Cell Phone (______)____________________ Cell Phone Carrier ________________________

Employer_____________________________ Occupation_____________________________

DENTAL INSURANCE (PRIMARY)

Insured's Name____

Name of Insurance Co.________________________________ Phone_____________________

ID#_________________________________ Group#________________________________

DENTAL INSURANCE (SECONDARY)

Insured's Name____

Name of Insurance Co.________________________________ Phone_____________________

ID#_________________________________ Group#________________________________

EMERGENCY CONTACT

In case of emergency, please contact:

Name____ Phone _______________________

Relationship__________________________

RELEASE

I authorize release of any information regarding my (or my child's) orthodontic treatment to my dental and/or medical insurance company.

______________________________________ __________________________

Signature (Parent/Guardian's signature if minor) Date