PATIENT INFORMATION

Date _____

Patient's Last Name_____ First Name_____ Middle Initial_____
Prefers to be called_____
Date of Birth_____
Gender: Male Female Other Preferred Pronoun_____

Home Address _____
City_____ State_____ Zip Code_____
Home Phone (_____)_____ Work Phone (_____)_____
Cell Phone (_____)_____ Cell Phone Carrier _____
Email_____

Please send appointment reminders: Text Email

Dentist's Name and Address_____

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_____

Insured's Date of Birth_____ Relationship to Patient_____

Name of Insurance Co._____ Phone_____

ID#_____ Group#_____

DENTAL INSURANCE (SECONDARY)

Insured's Name_____

Insured's Date of Birth_____ Relationship to Patient_____

Name of Insurance Co._____ Phone_____

ID#_____ Group#_____

EMERGENCY CONTACT

In case of emergency, please contact:

Name_____ Phone _____

Relationship_____

RELEASE

I authorize release, including electronic transmission, of any health information regarding my (or my child's) orthodontic treatment to my insurance company and consulting/co-treating doctors.

_____ _____

Signature Date

_____ _____

Signature of Parent/Guardian Date