

Patient Information

Date _____
Patient's Name _____ Nickname _____
 Address _____
 Birth Date ____/____/____ Age _____ Sex _____
 Cell Phone _____ Home Phone _____
 School _____ Grade _____
 Whom may we thank for referring you to our office? _____
 General Dentist _____ City _____
 Siblings: Name _____ Age _____ Name _____ Age _____

Responsible Party Information

Father's Name (or Self) _____
 Address _____
 How long at this address _____ Rent Own Previous Address (if less than 3 yrs) _____
 Cell Phone _____ Home Phone _____ Work Phone _____
 Social Security Number ____ - ____ - ____ Birth Date ____/____/____ Relationship to Patient _____
 Employer _____ Occupation _____ No. Years Employed _____
Mother's Name (or Spouse) _____
 Address _____
 How long at this address _____ Rent Own Previous Address (if less than 3 yrs) _____
 Cell Phone _____ Home Phone _____ Work Phone _____
 Social Security Number ____ - ____ - ____ Birth Date ____/____/____ Relationship to Patient _____
 Employer _____ Occupation _____ No. Years Employed _____
 Person financially responsible for this account Father/Self Mother
 Marital status single married divorced widowed

Orthodontic Insurance Information

Insured's Name _____ Birth Date ____/____/____ SSN ____ - ____ - ____
 Insurance Company _____ Group No. _____ Local No. _____
 Insurance Co Address _____ Phone _____
 Do you have dual coverage? Yes No
 2nd Insured's Name _____ Birth Date ____/____/____ SSN ____ - ____ - ____
 Insurance Company _____ Group No. _____ Local No. _____
 Insurance Co Address _____ Phone _____

Emergency Information

Name of nearest relative not living with you _____
 Complete Address _____
 Phone _____

This office reserves the right to verify the credit status of potential patients seeking payment terms.

Signature _____ **Date** _____

