

Patient Information

Date: _____

Patients Name _____ I prefer to be called _____
Last First Middle

Address _____ Gender _____ Age _____
Street City Zip

Home Phone _____ Cell Phone _____ Birthdate _____

E-Mail Address _____ School _____ Hobbies/Interests _____

Siblings/Children Yes No Name/Age _____ Name/Age _____ Name/Age _____

In case of emergency, Contact: Name _____ Phone _____ Relationship _____

Who may we thank for your referral? _____

Custodial Parent/Guardian (If patient is minor child)

Name _____ Relationship to patient _____
Last First Middle

Address _____ E-Mail address _____
Street City Zip

Home phone _____ Work phone _____ Cell phone _____

Spouse's name _____ Relationship to patient _____

Financial Responsible Party Information

Name _____ Relationship to patient _____
Last First Middle

Address _____ E-Mail address _____
Street City Zip

Home phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ Birthdate _____

Employer _____ Occupation _____ No. years employed _____

Spouse's name _____ Relationship to patient _____

Spouse's Employer _____ Occupation _____ No. years employed _____

Social security # _____ Birthdate _____ Work phone _____

Orthodontic Insurance Information

Insurance #1. _____

Insurance #2. _____

Subscriber's Name _____

Subscriber's Name _____

DOB ____/____/____ SSN ____-____-____

DOB ____/____/____/ SSN ____-____-____

Group # _____ ID# _____

Group # _____ ID # _____

Insurance Phone# _____

Insurance Phone # _____

Patient's relationship to subscriber _____

Patient's relationship to subscriber _____

Subscriber's employer _____

Subscriber's employer _____