

Welcome To Our Office

Patient Information

Patient Name _____ Age _____ Birthdate _____ Sex _____
Home Address _____ City, State, Zip _____
Home Phone _____ Cell/Work Phone _____
Family Members Treated Here? _____ Referred By _____
School Attended (if applicable) _____

Mother (if patient is under 18) ___ Stepmother ___ Guardian

Name _____ Home Phone _____
Home Address _____ City, State, Zip _____
Work Phone _____ Cell Phone _____

Father (if patient is under 18) ___ Stepfather ___ Guardian

Name _____ Home Phone _____
Home Address _____ City, State, Zip _____
Work Phone _____ Cell Phone _____

Primary Orthodontic Insurance

Insured's Name _____ Birthdate _____
SSN _____ Relationship to patient _____
Occupation _____ Employer _____
Employer's Address _____
Insurance Company _____ Phone _____
Claims Address _____
Group Number _____ Employee Number _____

Secondary Orthodontic Insurance

Insured's Name _____ Birthdate _____
SSN _____ Relationship to patient _____
Occupation _____ Employer _____
Employer's Address _____
Insurance Company _____ Phone _____
Claims Address _____
Group Number _____ Employee Number _____