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Specialist in Orthodontics for Children and Adults

WELCOME

Date _____

Patient's Name _____ Nickname _____

Address _____

Birthdate _____ Home Phone _____ Cell Phone _____

If patient is a minor, give parent's or guardian's name _____

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

RESPONSIBLE PARTY INFORMATION

Name _____ Work Phone _____ Cell Phone _____

Address: _____ Home Phone _____

How long at this address? _____ Relationship to Patient _____

Social Security Number _____ Birthdate _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Birthdate _____

I understand that a credit check may be required.

Initials

Signature of Financially Responsible Party

Date

PRIMARY INSURANCE

Insured's Name _____ Social Security # _____

Insurance Company _____ Employer _____ Group # _____

Insurance Co. Address _____ Insurance Co. Phone # _____

Do you have dual coverage? _____

Secondary Insured's Name _____ Social Security # _____

Secondary Insurance Company _____ Employer Group # _____

Secondary Insurance Co. Address _____ Insurance Co. Phone # _____