

PATIENT INFORMATION FORM

PATIENT INFORMATION

Name: _____
(Last) (First) (Middle)

Address: _____
(Street) (Apt. #)

(City) (State) (ZIP)

Birth Date: _____ Social Security Number: _____

Employer/School: _____ Occupation/Grade: _____

Home Phone: () _____ Work Phone: () _____

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

Dentist's Name _____ Dentist's Phone: () _____
(First) (Last)

NOTE: *If you would like us to accurately determine your orthodontic benefits and subsequently bill your insurance as a courtesy for any future treatment, insurance information must be **filled out completely** at the time of your initial examination.*

Do you have orthodontic insurance? No ___ Yes ___ Carrier: _____ Phone #: _____

Name of Primary Insured: _____ Primary's Employer: _____

Primary's Birth Date: _____ Primary's Social Security #: _____ Group/Plan No: _____

RESPONSIBLE PARTY INFORMATION

Name: _____
(Last) (First) (Middle)

Address: _____
(Street) (Apt. #)

(City) (State) (ZIP)

Previous Address (if less than 3 years): _____

SS#: _____ Birth Date: _____ Relationship to Patient: _____

Employer: _____ Occupation: _____ No. of Years Employed: _____

Home Phone: () _____ Work Phone: () _____

Spouse's Name: _____ Spouse's Employer: _____

Spouse's Occupation: _____ Spouse's Work Phone: () _____

EMERGENCY INFORMATION

Name of Nearest Relative Not Living With You: _____
(Last) (First)

Address: _____
(Street) (Apt. #)

(City) (State) (ZIP)

Phone: () _____ Relationship: _____

