



## THANK YOU FOR SELECTING OUR ORTHODONTIC TEAM

We will strive to provide you with the best orthodontic care. To help us meet your needs, please fill out this form completely. If you have any questions or need assistance, please ask us – we will be happy to help.

### PATIENT INFORMATION

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_  
 Home Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 E-Mail Address \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Person to Contact in Case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_

### RESPONSIBLE PARTY

Name of Person Responsible for this Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ SS# \_\_\_\_\_

### INSURANCE INFORMATION

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Social Security# \_\_\_\_\_ Date Employed \_\_\_\_\_  
 Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_  
 Ins Co Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Ins Co Phone # \_\_\_\_\_

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### DO YOU HAVE ADDITIONAL INSURANCE?    Yes    No    If Yes, Complete the following:

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Social Security# \_\_\_\_\_ Date Employed \_\_\_\_\_  
 Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_  
 Ins Co Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Ins Co Phone # \_\_\_\_\_

### Whom May We Thank for Referring You?

Please List any Special Interests (Sports, Hobbies, etc.)

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