



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 # _____

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.)
