

## PATIENT INFORMATION

Date _____	
Patient's Name _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address _____	City _____ Zip _____
Home Phone _____	Birthdate _____ Age _____ Social Security # _____
Patient's Dentist _____	Physician _____
If patient is a minor, give guardian's name _____	
Whom may we thank for referring you to our office? _____	
Name and ages of children in family _____	
Do you have any family members that have received orthodontic treatment in our office? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please list _____	

## RESPONSIBLE PARTY INFORMATION

•Name _____	Marital Status _____
Mailing Address _____	City _____ Zip _____
How long at this address? _____	Home Phone _____ Work Phone _____
Previous Address (if less than 3 years) _____	
Social Security # _____	Birthdate _____ Work Phone _____
Employer _____	Occupation _____ # of years employed _____
Employer's Address _____	City _____ Zip _____
•Spouse's Name _____	Relationship to patient _____
Social Security # _____	Birthdate _____ Work Phone _____
Employer _____	Occupation _____ # of years employed _____
Employer's Address _____	City _____ Zip _____

## ORTHODONTIC INSURANCE INFORMATION

Insured's Name _____	Insured's Soc. Sec. # _____
Insurance Company _____	Group # _____ Ins. Benefit \$ _____
Insurance Company Phone # _____	
Do you have dual coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes:	
Insured's Name _____	Insured's Soc. Sec. # _____
Insurance Company _____	Group # _____ Ins. Benefit \$ _____
Insurance Company Phone # _____	

## EMERGENCY INFORMATION

Who should we contact in case of an emergency? _____
Phone Number _____

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of Patient, Parent, of Guardian