Welcome

PATIENT PERSONAL INFORMATION

Name: ______________________________ M[ ] F[ ] Age: ______________ Birthday: __________

Address: ______________________________ City: ________________ Zip: ________________

Home Phone: ________________ Cell Phone: ______________ Spouse Name If Applicable: __________

PATIENT/RESPONSIBLE PARTY INFORMATION

Responsible Party (if not Patient): ____

RELATIONSHIP TO PATIENT [ ] parent [ ] other ________________________________

Responsible Party Home Phone: ______________ cell: ______________ work: ______________

Street Address: ____________________ City: ______________ State: __________ Zip: __________

Employers Name: __________________ Address: __________________ Phone No. ______________

PATIENT INSURANCE INFORMATION Please Present Insurance Card

PRIMARY Insurance Company Name: ________________________ Insurance Phone: ________________

Name of Insured: ____________________ Insured SS#: _____-_____-______ or ID# __________

Birthday: ____________ Employment of insured: ________________

SECONDARY Insurance Company Name: ____

Name of Insured: ____________________ Insured SS#: _____-_____-______ or ID# __________

Birthday: ____________ Employment of insured: ________________

EMERGENCY CONTACT

Who Should We Notify Locally, Other Than Spouse, In Case Of Emergency? ____________________

Relationship: ____________ Phone: ____________

Have any of your family members been seen in this office? Yes [ ] No [ ] Name ________________

Have you previously had braces [ ] yes [ ] no Whom may we thank for referring you? ____________

Reason For Today's Visit: ____

Do you want e-mail reminders of up coming appointments? E-mail address ____________________

I Understand and Agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account. I certify that this information is true and correct to the best of my knowledge.

______________________________ date ________________ PARENT/GUARDIAN SIGNATURE