Welcome to

About the Patient

Today's Date_____

Name_____

First Last MI

Nickname_____

Birthday __/__/____ Age____ M/F

School_____

Grade_____

Hobbies/Sports_____

_____

Other Family Members_____

_____

Orthodontic Insurance

Primary

Insured's Name_____

First Last MI

Relation to Patient_____

Insured's Birtdate __/__/____

Insured's Id #_____

Insured's Employer_____

Insurance Company_____

Insurance Address_____

Insurance Ph #_____

Group #_____

Emergency Information

Name_____

First Last MI

Relation to Patient_____

HM#_____ Cell #_____

WK#_____OT#_____

Mother's Information

Name_____

First Last MI

SS # _____

Birthday __/__/____ Age____

Single Married Divorced Widowed Separated

Spouces Name _____

Mailing Address_____

Home Address_____

City_____ ST_____ Zip_____

Time at Address_____

Please Circle the best number to be contacted at:

HM#_____ Cell #_____

WK#_____DL#_____

E-Mail Address_____

Employer_____

Occupation _____ #Years There_____

Father's Information

Name_____

First Last MI

SS # _____Relation to Pt_____

Birthday __/__/____ Age____

Single Married Divorced Widowed Separated

Spouces Name _____

Mailing Address_____

Home Address_____

City_____ ST_____ Zip_____

Time at Address_____

HM#_____ Cell #_____

WK#_____DL#_____

E-Mail Address_____

Employer_____

Occupation _____ #Years There_____

I understand that where appropriate, credit bureau reports may be obtained.

Signature_____Date_____