



WHO MAY WE THANK FOR RECOMMENDING US? \_\_\_\_\_

OTHER FAMILY MEMBERS IN OUR CARE? \_\_\_\_\_

NAME OF FAMILY DENTIST: \_\_\_\_\_ TOWN: \_\_\_\_\_

PATIENT: Full Name \_\_\_\_\_ Goes By: \_\_\_\_\_

Birthdate : \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_, Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone \_\_\_\_\_

Home Address: \_\_\_\_\_

RESPONSIBLE PARTY: Full Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**\*\*Email of Responsible Party** \_\_\_\_\_

\*\*\*\*use your email address to access your account and appointments\*\*\*\*

SS# \_\_\_\_\_

YOUTH PATIENT ONLY (Parent or Guardian is Responsible Party): Grade Level \_\_\_\_\_ School: \_\_\_\_\_ Who will usually bring patient to appointments? \_\_\_\_\_

Father: \_\_\_\_\_ Employed By: \_\_\_\_\_ Occupation: \_\_\_\_\_

Mother: \_\_\_\_\_ Employed By: \_\_\_\_\_ Occupation: \_\_\_\_\_

Patient Living With: \_\_\_\_\_

Brothers: \_\_\_\_\_ Sisters: \_\_\_\_\_

ADULT PATIENT ONLY: Occupation: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Patient's Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Employer Phone: \_\_\_\_\_

INSURANCE INFORMATION: Is patient covered by insurance for orthodontic care?

If so, policy holder's name: \_\_\_\_\_ DOB \_\_\_\_\_

SS# \_\_\_\_\_ Name of Insurance Co.: \_\_\_\_\_

Group Policy #: \_\_\_\_\_ Insurance Co. Phone#: \_\_\_\_\_

Employer Name Who Holds Group Policy: \_\_\_\_\_