



Welcome To Our Office

Patient's name _____ Nickname _____ Date _____
 Address _____ City _____ Zip _____
 Home phone _____ Cell phone _____ Birthdate _____ Age _____
 Email _____ School _____ Grade _____
 Dentist _____ Date of Last Visit _____
 Names and ages of siblings _____
 If patient is a minor, give parent's or guardian's name _____
 Whom may we thank for referring you to our office _____

Responsible Party Information

Name _____
 Address _____
 Mailing address(if different than above) _____
 How long at this address _____ Home phone _____ Work phone _____
 Previous address(if less than 3 years) _____
 Social security # _____ Birthdate _____ Relationship to patient _____
 Employer _____ Occupation _____ No. years employed _____
 Spouse's name _____
 Social security # _____ Birthdate _____ Work phone _____
 Employer _____ Occupation _____ No. years employed _____

Orthodontic Insurance Information Only

Insured's name _____ Insured's social security # _____
 Insurance company _____ Group no. _____ Local no. _____
 Insurance co. address _____
 Do you have dual coverage? ___No___ Yes; If yes then,
 Insured's name _____ Insured's social security # _____
 Insurance company _____ Group no. _____ Local no. _____
 Insurance co. address _____

Emergency Information

Name of nearest relative not living with you _____
 Complete address _____
 Relationship to patient _____ Phone _____

Signature(Parent's signature if minor) _____