CHILD

PATIENT INFORMATION

DATE ______________ AGE ____________

PATIENT'S NAME ____
LAST FIRST MIDDLE PREFERRED NAME

HOME ADDRESS ____
(ZIP CODE)

BIRTH DATE ______________ SEX ________ HOME PHONE ______________________________

WHOM MAY WE THANK FOR RECOMMENDING OUR SERVICES? ______________________________

NAMES AND AGES OF CHILDREN IN FAMILY HAVE ANY BEEN SEEN IN OUR OFFICE? YES NO

______________________________ ______ ______________________________ ______

______________________________ ______ ______________________________ ______

RESPONSIBLE PARTY INFORMATION

NAME ____
LAST FIRST MIDDLE MARITAL STATUS

HOME ADDRESS ____
(IF DIFFERENT THAN ABOVE) (ZIP CODE)

HOME PHONE ____________________ CELL PHONE ____________________ WORK PHONE ____________________

SOCIAL SECURITY # ____________________ BIRTH DATE ________________ RELATIONSHIP TO PATIENT __________

EMPLOYER ________________________ OCCUPATION ________________ NUMBER OF YEARS EMPLOYED ________

SPOUSE'S NAME ____ RELATIONSHIP TO PATIENT ____________

EMPLOYER ________________________ OCCUPATION ________________ NUMBER OF YEARS EMPLOYED ________

BIRTH DATE ______________ WORK PHONE ________________________ CELL PHONE ________________________

RESPONSIBLE PARTY EMAIL FOR APPOINTMENT REMINDERS, ETC. ______________________________

DENTAL INSURANCE

PRIMARY INSURANCE: *(IF INSURED'S ADDRESS IS DIFFERENT THAN RESPONSIBLE PARTY, PLEASE INFORM OUR OFFICE)*

INSURED'S FULL NAME ____ BIRTH DATE ______________

SOCIAL SECURITY # ____________________ RELATIONSHIP TO PATIENT ________________

INSURANCE COMPANY ________________________________ PHONE # ________________________

GROUP # ____________________ DOES POLICY HAVE ORTHODONTIC BENEFITS? YES NO DON'T KNOW

MEMBER ID # ____________________ INSURED'S EMPLOYER ________________________________

SECONDARY INSURANCE: *(IF INSURED'S ADDRESS IS DIFFERENT THAN RESPONSIBLE PARTY, PLEASE INFORM OUR OFFICE)*

INSURED'S FULL NAME ____ BIRTH DATE ______________

SOCIAL SECURITY # ____________________ RELATIONSHIP TO PATIENT ________________

INSURANCE COMPANY ________________________________ PHONE # ________________________

GROUP # ____________________ DOES POLICY HAVE ORTHODONTIC BENEFITS? YES NO DON'T KNOW

MEMBER ID # ____________________ INSURED'S EMPLOYER ________________________________

EMERGENCY INFORMATION

NAME OF NEAREST RELATIVE (NOT LIVING WITH YOU) ________________________________

PHONE NUMBER (S) ________________________________ RELATIONSHIP TO PATIENT ______________