

WELCOME



ABOUT THE PATIENT

Patient's Last Name (Please Print)	First	Middle Initial	Name Patient prefers to be called:	Sex (M or F)	Exam Date
Home Address:	Street	City	State	Zip Code	Home Phone Number
Patient's Age	Patient's Birthdate	Best Phone Number For this Office to Use (Please check box)			
		<input type="checkbox"/> Home	<input type="checkbox"/> Cell	<input type="checkbox"/> Work	

THIS SECTION IS FOR PATIENTS UNDER 18 YEARS OF AGE - PARENT OR GUARDIAN PLEASE COMPLETE

Marital Status of Mother and Father <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	Who is accompanying the patient today?		
Father's Name	Father's Social Security Number	Father's Employer	Work Phone #
Mother's Name	Mother's Social Security Number	Mother's Employer	Work Phone #
Patient's Activities (please list any hobbies, sports or musical instruments played)	School	Grade	
Name of Brothers and/or Sisters	Age	Name	Age
		Name	Age

ADULT PATIENTS - PLEASE COMPLETE THIS SECTION

Employer	Work Address	Work Phone #
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	If Married, Name of Spouse	Spouse's Social Security Number
Spouse's Employer	Spouse's Work Phone #	

PERSON RESPONSIBLE FOR THE ACCOUNT

Last Name (Please Print)	First	Middle Initial	Social Security Number	Relationship to Patient	
Billing Address:	Street	City	State	Zip Code	Home Phone #
Employer	Work Address	Work Phone #			

ORTHODONTIC INSURANCE (PRIMARY)

Insurance Company's Name	Group # (Plan, Local, or Policy #)		Insurance Company's Phone #
Insured's Name	Insured's Birthdate	Insured's Social Security Number	Insured's Employer
Insured's Relationship to Patient	Insured's Address		

ORTHODONTIC INSURANCE (SECONDARY)

Insurance Company's Name	Group # (Plan, Local, or Policy #)		Insurance Company's Phone #
Insured's Name	Insured's Birthdate	Insured's Social Security Number	Insured's Employer
Insured's Relationship to Patient	Insured's Address		

