Patient Information

Today's Date

Patient Name ______________________ Date of Birth ______________________

Patient's preferred first name or nickname ______________________

Gender ______________________

Address ______________________

City ______________________

State, Zip ______________________

Home Phone ______________________

Work Phone ______________________

Mobile Phone ______________________

Email ______________________

School/Occupation ______________________

Dentist's name: ______________________

How did you hear about us? ______________________

Who may we thank for referring you? ______________________

Other friends or family who are patients here? ______________________

Date of last dental check-up or cleaning: ______________________

Please describe the reason(s) you seek orthodontic treatment ______________________

If patient is a minor give parent or guardians name?

Responsible Party(s) "if different from above"
Name(s) of financially responsible party(s) / legal guardian(s)

Mother: ° Primary ° Secondary

Name ______________________

Relation to patient ______________________

Address ______________________

City ______________________

State & Zip ______________________

Home Phone ______________________

Work Phone ______________________

Mobile Phone ______________________

Email ______________________

Date of Birth ______________________

Social Security # ______________________

Employer ______________________

Insurance Company ______________________

Address ______________________

City ______________________

State & Zip ______________________

Insurance Phone ______________________

Father: ° Primary ° Secondary

Name ______________________

Relation to patient ______________________

Address ______________________

City ______________________

State & Zip ______________________

Home Phone ______________________

Work Phone ______________________

Mobile Phone ______________________

Email ______________________

Date of Birth ______________________

Social Security # ______________________

Employer ______________________

Insurance Company ______________________

Address ______________________

City ______________________

State & Zip ______________________

Insurance Phone ______________________