Patient/Family Information

Date _____

Marital Status

Patient Name _____Age _____ Birthdate_____ S M D W

Address _____City _____State_____Zip_____

Primary Contact Person _____ Relationship to Patient _____

Do you have insurance with orthodontic coverage? ☐ Yes ☐ No

*Confidential Responsible Party Information

Responsible Party _____ Relationship to Patient _____

Social Security Number _____ Date of Birth _____

Address _____City _____State_____Zip_____

How many years have you been at this address? _____ ☐ Own ☐ Rent

Home Phone _____ Cell Phone _____

Work Phone _____ Extension _____ Email _____

Employer _____Occupation _____# of yrs. Employed _____

Spouse's Name _____Relationship to Patient _____

Spouse's Social Security Number _____ Date of Birth _____

Spouse's Contact Numbers Cell Phone _____Work Phone _____

***I understand that all information above must be filled out completely and may be used for credit reference.**

_____ _____

Signature Date

Are there situations that we should know about (divorce etc.)? ☐ **Yes** ☐ **No** _____

With whom does the patient live? ☐ **Both Parents** ☐ **Mother** ☐ **Father** _____

Additional Family Information

Other Children/Siblings

Name _____ Age _____ Date of Birth _____

Name _____ Age _____ Date of Birth _____

Name _____ Age _____ Date of Birth _____

Name _____ Age _____ Date of Birth _____