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 dental insurance with orthodontic coverage? ☐ Yes ☐ No

Confidential Responsible Party/ Billing 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** _____

For future appointments, how would you like to be reminded: ☐ **Text** ☐ **Email** ☐ **Both Text and Email**

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 _____