PATIENT INFORMATION FORM

PATIENT INFORMATION

Name: (LAST) (FIRST) (MIDDLE INITIAL)

Address: (STREET) (APT #) (CITY, ST, ZIP)

Birthdate: SS #: Occupation:

Employer: # of Years Employed:

Work#: Home#: Cell#:

E-Mail Address:

Hobbies/Sports:

School: City of School:

Other family members seen by us (provide age):

Sibling(s) not listed above (current or treated elsewhere):

Whom may we THANK for referring you to our office?:

Dentist's Name:

City: Ph#: Last Visit Date:

Responsible Party's Signature: Today's Date:

INSURANCE INFORMATION

INSURANCE: We bill DENTAL Insurance (Ortho) AS A COURTESY. If you would like us to accurately determine your ORTHO benefits and subsequently bill your insurance for any future treatment, insurance information must be filled out completely BEFORE you come in for your initial appointment. *NOTE: No TMJ Treatment is billed in this office. It is the patient's responsibility to check for benefits, and to bill their insurance for TMJ Treatment.

Do you have DENTAL (Ortho) Insurance? ☐ No ☐ Yes Carrier:

Group/Plan#: Carrier Ph#:

Carrier Address:

Name of Primary Insured:

Primary Birthdate: Primary SS#:

Do you have Secondary Insurance? ☐ No ☐ Yes Carrier:

Group/Plan#: Carrier Ph#:

Carrier Address:

Name of Secondary Insured:

Secondary Birthdate: Secondary SS#:

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RESPONSIBLE PARTY INFORMATION

NOTE: If separated/divorced the responsible party of the child is the custodial parent. The person responsible for account and signing contract is the only person legally able to acquire any information regarding patient. If responsible party has legal custody of a person under 18 and the relationship to the person is not mother/father, please provide information below.

Name: Relationship to Patient:

Employer: Occupation:

# of Years Employed: Home#:

Cell#: SS#: Birthdate:

Billing Address: (STREET) (APT #) CITY, ST, ZIP)

Previous Address (If less than 3 years): (STREET) (APT #) CITY, ST, ZIP)

Mother's Information: ☐Stepmother ☐Guardian Name:

Birthdate: SS#: Home#:

Cell#:

Father's Information: ☐Stepfather ☐Guardian Name:

Birthdate: SS#: Home#:

Cell#:

Who is Responsible for Making Appointments?:

Name: Relationship to Patient:

Home Ph#: Cell Ph#:

If you are NOT the Patient or the Responsible Party filling out this form, please provide:

Name: Relationship to Patient:

Address: (STREET) (APT #) (CITY, ST, ZIP)

Home Ph#: Cell Ph#:

Signature: Today's Date:

EMERGENCY INFORMATION

Primary Physician's Name:

Physican's Address: (STREET) (APT #) (CITY, ST, ZIP)

Phone#:

Name of nearest relative NOT living with you:

Address: (STREET) (APT #) CITY, ST, ZIP)

Home#: Work#: Cell#:

I understand that credit bureau information may be obtained.

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