

1 BEGIN HERE: ADOLESCENT PATIENT INFORMATION

Today's Date: _____

Name: _____ Address: _____
First MI Last Nickname
Phone: _____ Birthday _____ Age: _____ Sex: _____ City: _____ State: _____ Zip: _____

2 BEGIN HERE: ADULT PATIENT INFORMATION (or parent information if patient is a child.) If joint contract, both mother and father info need to be completed.

FATHER or SELF/GUARDIAN INFORMATION

Name: _____ Address: _____
First MI Last
City: _____ State: _____ Zip: _____
E-mail Address: _____
Home Phone: _____ Work Phone: _____
Birthday _____ Age: _____ Sex: _____ Marital Status: _____
Driver's License # _____ S.S. # _____

EMPLOYER/INSURANCE INFORMATION

Employer Name: _____
Employer Address: _____
Employer City: _____ State: _____ Zip: _____
Number of Years Employed _____ Occupation _____
Orthodontic Coverage? Yes _____ No _____
Insurance Company Name: _____
Insurance Address: _____
Insurance City: _____ State: _____ Zip: _____
Insurance Phone: _____ ext: _____
Group #: _____ Local or Union # _____

MOTHER or SPOUSE INFORMATION

Name: _____ Address: _____
First MI Last
City: _____ State: _____ Zip: _____
E-mail Address: _____
Home Phone: _____ Work Phone: _____
Birthday _____ Age: _____ Sex: _____ Marital Status: _____
Driver's License # _____ S.S. # _____

EMPLOYER/INSURANCE INFORMATION

Employer Name: _____
Employer Address: _____
Employer City: _____ State: _____ Zip: _____
Number of Years Employed _____ Occupation _____
Orthodontic Coverage? Yes _____ No _____
Insurance Company Name: _____
Insurance Address: _____
Insurance City: _____ State: _____ Zip: _____
Insurance Phone: _____ ext: _____
Group #: _____ Local or Union # _____

3 OTHER INFORMATION

Who is the Responsible Party: _____ Who may we thank for referring you? _____
Dentist Name: _____ Sports or Hobbies: _____
Physician Name: _____ Other Children: _____ Birthday: _____
School Name: _____ Grade: _____ Other Children: _____ Birthday: _____