WELCOME TO OUR PRACTICE

Patient's information

Patient's name		Social Security #
Address	City	Zip code
Home Phone #	cell #	Birthdate

Responsible Party Information

Name		Marital status
If patient is a minor, are you the legal guardian?		E-mail address
Address		Zip code
Home phone #	Cell #	Work phone #
Social Security #	Birthdate	Relationship to patient
Employer	Occupation	No. years employed
Spouse's/other parent name		relationship to patient
Employer	Occupation	No. Years employed
Social security #	Birthdate	Work phone #

Dentist information

Dentist name	Phone #
Address	Last check up and cleaning date

Emergency Information

Name of nearest relative **not** living with you	
Complete address	Zip code
Phone #	Relationship

Insurance Information

Policy holder's name	Social Security #
Birthdate	Employer
Insurance Company	Insurance phone #
Insurance address	Group #

I hereby authorize payment of dental benefits directly to my orthodontist. I agree to be responsible for all dental services and materials not paid by my dental insurance

________________________________ ________________________

Signature Date