Date _____

Patients's Name _____ Nickname _____

Patient's Address _____City _____State _____ Zip _____

Patients Employer/Occupation_____

Patient's Phone # _____Patient's email _____

Who is financially responsible for the patient's treatment/account? _____

Father's Name _____ S.S.# _____

Address_____

Occupation _____

Firm Name_____Work Phone_____

Cell Phone_____Email address_____

Dental Insurance? ❑ Yes ❑ No Name of Insurance Company _____

Mother's Name _____ S.S.# _____

Address_____

Occupation _____

Firm Name_____Work Phone_____

Cell Phone_____Email address_____

Dental Insurance? ❑ Yes ❑ No Name of Insurance Company _____

How did you first learn about our office? _____

Who may we thank for referring you to our office? _____

Patient's Dentist? _____

Who should we call in case of emergency? _____

Phone #_____ Relationship? _____

Patient's Birth Date Month / Day / Year Patient's Age _____

Are you now in good dental health? ❑ Yes ❑ No

Any medical problems? _____

Are you allergic to any medications? _____

Have you been examined by an orthodontist before? ❑ Yes ❑ No

When _____Where _____

Recommendations? _____

_____

What, in your opinion, is the orthodonic problem? _____

I ACKNOWLEDGE THAT THE INFORMATION I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE, THAT IT WILL BE HELD IN THE STRICTEST OF CONFIDENCE, AND THAT IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY/MY CHILD'S HEALTH STATUS. I ALSO UNDERSTAND THAT THE OFFICE RESERVES THE RIGHT TO VERIFY THE CREDIT STATUS OF POTENTIAL PATIENTS AND/OR PARENTS PRIOR TO EXTENDING CREDIT FOR TREATMENT FEES, AND MAY AT THE DISCRETION OF THE OFFICE, USE THE SERVICES OF ONE OR MORE CREDIT REPORTING SERVICES. IF INSURANCE IS INVOLVED, I AUTHORIZE THE RELEASE OF INFORMATION FOR THE PAYMENT OF CLAIMS, AND I AUTHORIZE THE INSURANCE COMPANY TO PAY THE OFFICE.

PATIENTS UNDER THE AGE OF 26 WILL BE REQUIRED TO HAVE A PARENT/GUARDIAN COSIGNER PRESENT AT TREATMENT START VISIT UNLESS OTHER ARRANGEMENTS ARE MADE. It is recommended that the parent/guardian also come to the initial appointment.

_____ _____

Signature of Patient (Parent/Gaurdian signature if patient is under age 18) Person Responsible for Treatment Fees