

PATIENT INFORMATION

Name _____ Sex ____ Phone _____ Birthday _____ Age _____
 Address _____ City _____ State _____ Zip _____

RESPONSIBLE PARTY INFORMATION

<u>FATHER or SELF or GUARDIAN INFORMATION</u>	<u>MOTHER or SPOUSE INFORMATION</u>
Name _____	Name _____
Address _____	Address _____
City _____ State ____ Zip _____	City _____ State ____ Zip _____
How long at this address _____	How long at this address _____
Previous Address (if less than 3 yrs) _____	Previous Address (if less than 3 years) _____
Home Phone _____ Work/Cell _____	Home Phone _____ Work/Cell _____
Birthday _____ Age ____ Sex ____ Marital Status ____	Birthday _____ Age ____ Sex ____ Marital Status ____
S.S. # _____	S.S. # _____
EMPLOYER INFORMATION	EMPLOYER INFORMATION
Employer Name _____	Employer Name _____
Employer Address _____	Employer Address _____
Employer City _____ State ____ Zip _____	Employer City _____ State ____ Zip _____
Occupation _____ # Yrs. Employed _____	Occupation _____ # Yrs. Employed _____
Orthodontic Coverage? Yes ____ No ____	Orthodontic Coverage? Yes ____ No ____
Insurance Company Name _____	Insurance Company Name _____
Insurance Address _____	Insurance Address _____
Insurance City _____ State ____ Zip _____	Insurance City _____ State ____ Zip _____
Insurance Phone _____ Ext _____	Insurance Phone _____ Ext _____
Group # _____	Group # _____

OTHER INFORMATION

Who is the responsible party? _____	Dentist Name _____
Other children _____ Age _____	Who may we thank for referring you? _____
_____ Age _____	_____
_____ Age _____	Physician Name _____
_____ Age _____	School Name _____ Grade _____
Sports or Hobbies _____	

