About You

Name: _____
First Last Mi

Common name: _____ Sex: M F

Birthdate: ___/___/___ Age:_____ S.S.# _____

Phone #:(____) _____ Cell #:(____) _____

Email Address: _____

Address: _____

_____
City State Zip

Employer: _____ Years of Service? _____

Occupation: _____ Work Phone: (____) _____
Marital Status: Single Married Divorced Widowed Partnered

Hobbies/Interests: _____

Other family members seen by us: _____

Whom may we thank for referring you? _____

Dentist Name: _____ Last Visit:_____

Spouse / Emergency Contact

Name: _____ Relation: _____
First Middle Last

Phone #:(____) _____ Cell #:(____) _____

Person Responsible For Account

Name: _____ Relation: _____

Phone #: (____)_____ Birthdate: ____/____/____

Billing Address: _____

_____
City State Zip

Years There _____ Own Home _____ Rent Home _____

___ Employed ___ Retired ___ Unemployment Comp ___ Other

Occupation ___ Professional ___ Sales/Admin ___ Trade/Tech
___ None___ Service ___ Military Officer ___ Enlisted

Participate in one of the following ____ HSA ____ FSA

Insurance

Dental Coverage Y N Ortho Coverage Y N

Primary

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group Name: _____ Group #: _____

Policy Owner's Name: _____

Policy Owner's SS/ID#: _____ Birthdate: _____

Relationship to patient: _____

Policy Owner's Employer: _____

Is the patient covered by another Orthodontic Policy? Y N

Secondary

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group Name: _____ Group #: _____

Policy Owner's Name: _____

Policy Owner's SS/ID#: _____ Birthdate: _____

Relationship to patient: _____

Policy Owner's Employer: _____

Insurance Assignment

If this office accepts my insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including the examination, diagnosis and records of treatment rendered to my insurance company.

_____
SIGNATURE DATE