1722-O (7/16)

ABOUT THE PATIENT: PLEASE ANSWER ALL QUESTIONS

PATIENT'S NAME | FAVORITE NAME (IF DIFFERENT) | SEX ☐ M ☐ F | AGE | DATE OF BIRTH / /

ADDRESS | HOME PHONE

CITY | STATE | ZIP | WORK / CELL PHONE

SCHOOL | GRADE | DO YOU HAVE A HOBBY? ☐ YES ☐ NO IF YES, WHAT?

MAIN CONCERN >

HAS THE PATIENT SEEN ANOTHER ORTHODONTIST? ☐ YES ☐ NO IF YES, NAME ORTHODONTIST:

HOW WERE YOU REFERRED TO OUR PRACTICE? ☐ DENTIST ☐ INSURANCE PLAN ☐ SIGNAGE ☐ WEBSITE

☐ EMPLOYEE / FAMILY MEMBER _____ ☐ ACQUAINTANCE _____ ☐ OTHER _____

HAS THE PATIENT OR ANOTHER FAMILY MEMBER BEEN TO OUR OFFICE BEFORE?

☐ YES ☐ NO IF YES, WHO?

FAMILY DENTIST | CITY | DATE OF LAST CHECK-UP / /

PERSON WHO ACCOMPANIES PATIENT TO EXAM APPOINTMENT

PERSON(S) WITH PATIENT AT EXAM | RELATIONSHIP TO PATIENT

FAMILY STATUS ☐ M ☐ S ☐ WID ☐ SEP ☐ DIV

PATIENT LIVES WITH ☐ BOTH PARENTS ☐ MOTHER ☐ FATHER ☐ OTHER

ABOUT THE RESPONSIBLE PARTY **PLEASE NOTE: Holding Insurance Does Not Make You The Responsible Party*

NAME OF PERSON WHO WILL BE RESPONSIBLE FOR PAYMENT ON ACCOUNT | DOB OF RESPONSIBLE PARTY

ADDRESS OF RESPONSIBLE PARTY | HOME PHONE

CITY | STATE | ZIP | CELL PHONE

SOCIAL SECURITY NUMBER OF RESPONSIBLE PARTY | RELATIONSHIP TO PATIENT | WORK PHONE

EMPLOYER | EMAIL ADDRESS:

EMPLOYER ADDRESS

EMERGENCY CONTACT INFORMATION

WHO SHOULD WE CONTACT IN CASE OF EMERGENCY? NAME | HOME PHONE

ADDRESS | CELL PHONE

ABOUT THE INSURANCE HOLDER **The Holder Of The Insurance May Not Be The Responsible Party*

PRIMARY DENTAL INSURANCE

POLICY HOLDER NAME

POLICY HOLDER ADDRESS

CITY | STATE | ZIP

ID ON CARD | SOCIAL SECURITY #

DATE OF BIRTH OF POLICY HOLDER | RELATIONSHIP TO PATIENT

EMPLOYER OF INSURANCE HOLDER

INSURANCE CO. NAME

GROUP # OF INSURANCE CO.

ADDRESS OF INSURANCE CO.

PHONE # OF INSURANCE CO. | PLAN(S) EFFECTIVE DATE

SECONDARY DENTAL INSURANCE

POLICY HOLDER NAME

POLICY HOLDER ADDRESS

CITY | STATE | ZIP

ID ON CARD | SOCIAL SECURITY #

DATE OF BIRTH OF POLICY HOLDER | RELATIONSHIP TO PATIENT

EMPLOYER OF INSURANCE HOLDER

INSURANCE CO. NAME

GROUP # OF INSURANCE CO.

ADDRESS OF INSURANCE CO.

PHONE # OF INSURANCE CO. | PLAN(S) EFFECTIVE DATE

I HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS ALLOWABLE UNDER MY DENTAL PLAN(S) DIRECTLY TO DEERWOOD ORTHODONTICS.

NAME _____ # _____

_____

SIGNED (PATIENT OR PARENT, IF MINOR) **DATE**

PATIENT ACCOUNT REGISTRATION