



WELCOME TO THE ORTHODONTIST



Our goal is to help your child reach and maintain good oral health and a beautiful smile that lasts a lifetime.

1 Tell Us About Your Child

Today's Date: _____ Nickname: _____

Child's Name: _____ M F
LAST FIRST MI

Birthdate: ____ / ____ / ____ Age: ____ SS #: _____

School: _____ Grade: _____

Hobbies / Sports: _____

Child's Home # (_____) _____

Child's Home Address: _____
CITY STATE ZIP

E-mail Address: _____

4 Person Responsible for Account

Name: _____ Relation: _____

Billing Address: _____
CITY STATE ZIP

Previous Address: _____
CITY STATE ZIP

Hm # (_____) _____ DL #: _____

Employer: _____

Wk # (_____) _____ SS #: _____

Who is responsible for making appointments?

Name: _____

Wk # (_____) _____ Hm # (_____) _____

2 Who is Accompanying Your Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? Yes No

Whom may we thank for referring you? _____

List other family members seen by us _____

General Dentist: _____

Date of last cleaning / visit: _____

Parent's Marital Status: Single Partnered Divorced
 Married Separated Widowed

3 Parental Information

Mother Stepmother Guardian

Name: _____ Birthdate ____ / ____ / ____

Wk # (_____) _____ Hm # (_____) _____

Employer: _____

How long at current job: _____ Job Title: _____

SS #: _____ DL #: _____

Father Stepfather Guardian

Name: _____ Birthdate ____ / ____ / ____

Wk # (_____) _____ Hm # (_____) _____

Employer: _____

How Long at Current Job: _____ Job Title: _____

SS #: _____ DL #: _____

5 Primary Orthodontic Insurance

Orthodontic Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone # (_____) _____

Group # (Plan, Local or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____ / ____ / ____ **ID #:** _____

Policy Owner's Employer: _____

Employer's Address: _____

Secondary Orthodontic Insurance

Orthodontic Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone # (_____) _____

Group # (Plan, Local or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____ / ____ / ____ **ID #:** _____

Policy Owner's Employer: _____

Employer's Address: _____

