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Child Patient Information:

Date: _____

Patient's Name _____

Date of Birth: _____ Age: _____ Male or Female (please circle)

Patient's primary residence? Mother/Father (please circle)

Father's Name: _____

Address: _____

_____

Home # (father) _____Cell # (father) _____

Work # (father) _____Email (father) _____

Mother's Name: _____

Address: _____

_____

Home # (mother) _____Cell # (mother) _____

Work # (mother) _____Email (mother) _____

Which parent is financially responsible for this account? _____

General Dentist: _____ Phone # _____

Date of Last Visit to General Dentist: _____

Whom may we thank for referring you? _____

Family Members Who Have Had Orthodontic Treatment at this Office: _____

Have you consulted an Orthodontist before? Yes _____ No _____

If yes, whom: _____

Why are you seeking Orthodontic Care? _____

Insurance Information:

Do you have Orthodontic Insurance? Yes _____ No _____

Name of Policy Holder: _____

Name of Insurance Carrier: _____

ID# _____ Date of Birth: (Policy Holder) _____

Social Security #: (Policy Holder) _____

Is the patient covered by additional Orthodontic Insurance? Yes _____ No _____

Name of Policy Holder: _____

Name of Insurance Carrier: _____

ID# _____ Date of Birth: (Policy Holder) _____

Social Security #: (Policy Holder) _____