PATIENT INFORMATION FORM

PATIENT INFORMATION

Name: _____ (LAST) _____ (FIRST) _____ (MIDDLE INITIAL)

Address: _____ (STREET) _____ (APT #) _____ (CITY, ST, ZIP)

Birthdate: _____ SS #: _____ Occupation: _____

Employer: _____ # of Years Employed: _____

Work #: _____ Home #: _____ Cell #: _____

E-Mail Address: _____

Hobbies/Sports: _____

School: _____ City of School: _____

Other family members seen by us (provide age): _____

Sibling(s) not listed above (current or treated elsewhere): _____

Whom may we THANK for referring you to our office? _____

Dentist's Name: _____ City: _____ Ph #: _____ Last Visit Date: _____

Responsible Party's Signature: _____ Today's Date: _____

INSURANCE INFORMATION

INSURANCE: We bill DENTAL Insurance (Ortho) AS A COURTESY. If you would like us to accurately determine your ORTHO benefits and subsequently bill your insurance for any future treatment, insurance information must be filled out completely BEFORE you come in for your initial appointment.
*NOTE: No TMJ treatment is billed in this office. It is the patient's responsibility to check for benefits, and to bill their insurance for TMJ treatment.

Do you have DENTAL Insurance (Ortho)? ☐No ☐Yes Carrier: _____ Group/Plan #: _____

Carrier Address: _____ Carrier Ph #: _____

Name of Primary Insured: _____ Primary Birthdate: _____ Primary SS#: _____

Do you have Secondary Insurance? ☐No ☐Yes Carrier: _____ Group/Plan #: _____

Carrier Address: _____ Carrier Ph #: _____

Name of Secondary Insured: _____ Secondary Birthdate: _____ Secondary SS#: _____

RESPONSIBLE PARTY INFORMATION

Note: If separated/divorced the responsible party of the child is the custodial parent. The person responsible for account and signing contract is the only person legally able to acquire any information regarding patient. If responsible party has legal custody of a person under 18 and the relationship to the person is not mother/father, please provide information below.

Name: _____ Relationship to Patient: _____

Employer: _____ Occupation: _____ # of Years Employed: _____

Home #: _____ Cell #: _____ SS #: _____ Birthdate: _____

Billing Address: _____ (STREET) _____ (APT #) _____ CITY, ST, ZIP)

Previous Address (If less than 3 years): _____ (STREET) _____ (APT #) _____ CITY, ST, ZIP)

Mother's Information: ☐Step Mother ☐Guardian Name: _____ Birthdate: _____

SS #: _____ Home #: _____ Cell #: _____

Father's Information: ☐Step Father ☐Guardian Name: _____ Birthdate: _____

Who is Responsible for Making Appointments? Name: _____

Relationship to Patient: _____ Home Ph #: _____ Cell Ph #: _____

If you are NOT the <u>Patient</u> or the <u>Responsible Party</u> filling out this form, please provide:

Name: _____ Relationship to Patient: _____

Address: _____ (STREET) _____ (APT #) _____ CITY, ST, ZIP) Home Ph #: _____ Cell Ph #: _____

Signature: _____ Today's Date: _____

EMERGENCY INFORMATION

Primary Physician's Name: _____ Phone #: _____

Physican's Address: _____ City: _____

Name of nearest relative NOT living with you: _____

Address: _____ (STREET) _____ (APT #) _____ (CITY, ST, ZIP)

Home #: _____ Work #: _____ Cell #: _____

I understand that credit bureau information may be obtained.