

WELCOME TO THE ORTHODONTIST

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1

Tell Us About Your Child

Today's Date: ___/___/___ Male Female

Child's Name: _____
LAST FIRST MI

Nickname: _____ SS#: _____

Child's Birthdate: ___/___/___ Child's Age: _____

School: _____ Grade: _____

Hobbies / Sports: _____

Child's Home #: (____) _____

Child's Home Address: _____
APT/CONDO #

CITY STATE ZIP

E-Mail Address: _____

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 brothers / sisters with age: _____

General Dentist: _____

Last Visit Date: _____

Parent's Marital Status: Single Widowed
 Married Divorced Separated

3

Mother's Information: Step Mother Guardian

Name: _____ Birthdate: ___/___/___

Wk #: (____) _____ Ext: ____ Hm #: (____) _____

Employer: _____

How Long at Current Job: _____ Job Title: _____

SS #: _____ DL #: _____

Father's Information: Step Father Guardian

Name: _____ Birthdate: ___/___/___

Wk #: (____) _____ Ext: ____ Hm #: (____) _____

Employer: _____

How Long at Current Job: _____ Job Title: _____

SS #: _____ DL #: _____

4

Person Responsible For Account

Name: _____ Relation: _____

Billing Address: _____
CITY STATE ZIP

Previous Address: _____
CITY STATE ZIP

Hm #: (____) _____ DL #: _____

Employer: _____

Wk #: (____) _____ Ext: ____ SS #: _____

Who is responsible for making appointments?

Name: _____

Wk #: (____) _____ Ext: ____ Hm #: (____) _____

Neighbor or Relative not living with you.

Name: _____ Phone: (____) _____

Address: _____
CITY STATE ZIP

5

Primary Insurance

Dental Coverage? Yes No Ortho 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: ___/___/___ SS #: _____

Policy Owner's Employer: _____

Secondary Insurance

Dental Coverage? Yes No Ortho 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: ___/___/___ SS #: _____

Policy Owner's Employer: _____