Member American Association of Orthodontics

WELCOME

Date _____

Patient's Name _____
Last Name First Name Middle Initial

Name patient prefers to be called_____( ) Female ( ) Male

Age_____ Birth Date_____/_____/_____ Grade_____School_____
Month Day Year

Patient's Address_____Patient's Email _____

City_____State_____Zip_____

Home Phone ( ) _____Cell Phone ( ) _____

Your Regular Dentist_____Interests/Hobbies _____

Brothers or Sisters - Names: Birth dates Brothers or Sisters - Names: Birth dates

_____ _____/_____/_____ _____ _____/_____/_____

_____ _____/_____/_____ _____ _____/_____/_____

Have other family members had an orthodontic evaluation or braces here? Yes / No Whom? _____

Thank You for coming. Did someone tell you about us or refer you? Yes / No Whom?_____

Father/Guardian

Name _____Date of Birth _____/_____/_____ Soc. Security #_____-_____-_____
Month Day Year

Home Address _____Email_____
(If different from child)

Home Phone ( )_____Work Phone ( ) _____Cell Phone ( ) _____

Employer_____Address_____

Father's Dental/Orthodontic Insurance Yes / No Name of Company _____
(If different from spouse)

Mother/Guardian

Name _____Date of Birth _____/_____/_____ Soc. Security #_____-_____-_____
Month Day Year

Home Address_____Email _____
(If different from child)

Home Phone ( ) _____Work Phone ( ) _____Cell Phone ( ) _____

Employer_____Address_____

Mother's Dental/Orthodontic Insurance Yes / No Name of Company _____
(If different from spouse)

Additional Orthodontic Insurance (If not listed above)

Name of Insurance Co._____Employer_____

Policyholder Name_____Address_____

Relationship to Patient _____Date of Birth _____/_____/_____ Soc. Security #_____-_____-_____
Month Day Year

Emergency Contact: _____Phone _____

I verify that the above information is true and correct. If applicable, I authorize this office to file to my Insurance Company(s) any information that facilitates the use of my insurance benefits. I understand that my insurance is a contract that I have between my employer and the insurance company and that I am responsible for all charges not paid by my insurance company.

_____ _____
Signature of Parent/Legal Guardian Date

I agree that pictures taken of my child may be displayed in the office.

_____ _____
Signature of Parent/Legal Guardian Date