

SPECIALISTS IN ORTHODONTICS GENERAL PATIENT INFORMATION

DATE: _____

FIRST _____ MIDDLE _____ LAST _____ GENDER: M / F

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EMAIL (For Appointment Reminders): _____ AGE: _____ BIRTHDATE: ____ / ____ / ____

HOME PHONE: () _____ WORK PHONE: () _____ CELL PHONE: () _____

RESPONSIBLE PARTY: _____ RELATIONSHIP TO PATIENT: _____

RESP. PARTY SOCIAL SECURITY #: _____ RESPONSIBLE PARTY DOB: _____

ADDRESS FOR STATEMENTS (if different from above): _____

CITY: _____ STATE: _____ ZIP: _____

HAS ANY FAMILY MEMBER BEEN A PATIENT HERE? YES NO NAME: _____

HAS ANY FAMILY MEMBER WORN BRACES BEFORE? YES NO WHO WAS THE ORTHODONTIST? _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: () _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

WHEN WAS THE LAST TIME YOU VISITED A DENTIST OFFICE? _____ DENTIST: _____ Phone: _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE? Name: _____

HOW MANY WAYS HAVE YOU HEARD OF SPECIALISTS IN ORTHODONTICS? Friend Name: _____

General Dentist SIO Patient Website / Internet Insurance Plan SIO Employee
 Yellow Pages TV / Radio Direct Mail Your Company Billboard / Office Sign

IF PATIENT IS AN ADULT

EMPLOYER: _____

ADDRESS: _____

POSITION: _____

PHONE NUMBER: () _____

SOCIAL SECURITY #: _____

SPOUSE: _____

EMPLOYER: _____

ADDRESS: _____

PHONE NUMBER: () _____

SOCIAL SECURITY #: _____

IF PATIENT IS A CHILD

PARENT/LEGAL GUARDIAN: _____

EMPLOYER: _____

POSITION: _____

WORK PHONE NUMBER: () _____

SOCIAL SECURITY #: _____

MARITAL STATUS: MARRIED SEPARATED DIVORCED WIDOWED

**If Parent/Legal Guardian is not the financial responsible party
(i.e. grandparent or aunt paying account)**

FINANCIAL RESP. PARTY: _____

EMPLOYER: _____

POSITION: _____

WORK PHONE NUMBER: () _____

SOCIAL SECURITY #: _____

DATE OF BIRTH: _____

PRIMARY ORTHODONTIC INSURANCE OR PRE-PAID PLAN

POLICY HOLDER: _____

BIRTHDATE: _____ EMPLOYER: _____

INSURANCE COMPANY: _____

INSURANCE PHONE: () _____

ADDRESS: _____

POLICY / GROUP #: _____

EMPLOYEE ID #: _____

SECONDARY INSURANCE

POLICY HOLDER: _____

BIRTHDATE: _____ EMPLOYER: _____

INSURANCE COMPANY: _____

INSURANCE PHONE: () _____

ADDRESS: _____

POLICY / GROUP #: _____

EMPLOYEE ID #: _____

INFORMATION AND PAYMENT AUTHORIZATION RELEASE

I AUTHORIZE THE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM AND UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT AND AUTHORIZE PAYMENT DIRECTLY TO SPECIALISTS IN ORTHODONTICS OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

SIGNATURE (Responsible Party)

DATE