New Patient Form

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Patient Information: **PLEASE CHECK THE BELOW INFORMATION FOR ACCURACY**

Patient's Last Name _____ First name_____ Middle Initial _____

Address _____

Prefers to be called_____ Hobbies/Activities_____

Birthdate _____ Gender _____ Best Contact Phone _____

Email Address _____

Family Information: **PLEASE COMPLETE THIS SECTION ONLY IF THE PATIENT IS A CHILD.**

Are the patients parents: Married Separated Divorced Remarried Widowed Single

Custodial Parent(s) Name(s): _____

Patient Lives with (circle all that apply): Mother Father Stepmother Stepfather Grandparents Other _____

Are there any other adults we should know about? _____

Guardian 1 full name _____ Title Mr. Mrs. Ms. Dr. Other ___

Address (if different from patients) _____

Employer _____ Email Address _____

Home Phone (if different) _____ Cell Phone _____

Work Phone _____ Relationship _____

Guardian's 2 full name _____ Title Mr. Mrs. Ms. Dr. Other ____

Address (if different from patients)_____

Employer _____ Email Address _____

Home Phone (if different)_____ Cell Phone_____

Work Phone_____ Relationship _____

Financial Responsibility: **Please check the below information for accuracy**

Who is financially responsible for this account? _____

Who should receive financial information? _____

Address (if different from above) _____ Social Security Number _____

Best Contact # _____ Email Address _____ Employer_____

Financially Responsible Party Signature _____ Date _____

Dental Insurance: Please list only dental insurance policies.

Primary policy holder's full name _____ Birthday_____

Insurance Company _____ Employer_____

Claim Mailing Address _____ Relationship to patient_____

Subscriber ID or Social Security Number _____ Group #_____

Does this policy have orthodontic benefits? Yes No

Secondary policy holder's full name _____ Birthday_____

Insurance Company _____ Employer _____

Claim Mailing Address _____ Relationship to patient_____

Subscriber ID or Social Security Number _____ Group # _____

Does this policy have orthodontic benefits? Yes No

RELEASE AND WAIVER

I authorize the release of any information regarding my child's orthodontic treatment to my dental and /or medical insurance company.

Parent/Guardian Signature _____ Date _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my child's medical or dental health.

Parent/Guardian Signature _____ Date _____

Please return at your next appointment. Thank you!