PATIENT INFORMATION

NAME: (last) ____________ (first) ____________ (middle) ____________ SEX: M____ F____

BIRTHDATE: ____/____/______ AGE: ____ SS# ____________ EMAIL: ____________

ADDRESS: (street) ____________ (city) ____________ (state) ________ (zip) ________

PHONE#: ____________ DENTIST: ____________

WHOM MAY WE THANK FOR TELLING YOU ABOUT OUR OFFICE? ____________

FAMILY INFORMATION

FATHER'S (or Husband's) NAME: ____________ PHONE# (if different from Patient): ____________

ADDRESS (if different from Patient): ____________

MOTHER'S (or Wife's) NAME: ____________ PHONE # (if different from Patient): ____________

ADDRESS (if different from Patient): ____________

RESPONSIBLE PARTY INFORMATION

NAME: (last) ____________ (first) ____________ (m.i.) ______ MARITAL STATUS: ________

RESIDENCE: (street) ____________ (city) ____________ (state) ______ (zip) ______

MAILING ADDRESS: (street) ____________ (city) ____________ (state) ______ (zip) ______

YEARS AT THIS ADDRESS: ________ HOME PHONE #: ____________ CELL #: ____________

MAILING ADDRESS: (street) ____________ (city) ____________ (state) ______ (zip) ______

SOCIAL SECURITY #: ____________ BIRTHDATE: ____/____/______ RELATIONSHIP TO PATIENT: ________

EMPLOYER: ____________ PHONE#: ____________ POSITION: ____________ HOW LONG? ______

SPOUSE'S NAME: (last) ____________ (first) ____________ (m.i.) ________ CELL#: ____________

SOCIAL SECURITY #: ____________ BIRTHDATE: ____/____/______ RELATIONSHIP TO PATIENT: ________

EMPLOYER: ____________ PHONE#: ____________ POSITION: ____________ HOW LONG? ______

DENTAL INSURANCE INFORMATION

SUBSCRIBER'S NAME: ____________ BIRTHDATE: ______/______/______

SOCIAL SECURITY #: ____________ EMPLOYER: ____________

INSURANCE COMPANY: ____________ POLICY # / GROUP#: ____________

INSURANCE CO. ADDRESS: ____________ PHONE#: ____________

DO YOU HAVE DUAL COVERAGE? YES ❑ NO ❑ IF YES:

SUBSCRIBER'S NAME: ____________ BIRTHDATE: ______/______/______

SOCIAL SECURITY #: ____________ EMPLOYER: ____________

INSURANCE COMPANY: ____________ POLICY # / GROUP#: ____________

INSURANCE CO. ADDRESS: ____________ PHONE#: ____________

EMERGENCY INFORMATION

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU: ____________ RELATIONSHIP: ____________

COMPLETE ADDRESS: ____________

PHONE: ____________

I REALIZE IT MAY BE APPROPRIATE TO UTILIZE A CREDIT REPORT IN DETERMINING A PAYMENT PLAN.

SIGNATURE (Parent's signature if minor): ____________ DATE: ____________

UPDATES (date & initial): ________ ________ ________ ________ ________ ________

Name: ______________________________ Age ________ Today's Date: ____________

Alignment

Profile: Nose + 0 – / Lips + 0 – / Chin + 0 –

Transverse: CO ___|___ CR ___|___

A P Class R __________ L __________ OJ__________

Vertical OB______________

Erupted Teeth

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

Preliminary Diagnosis ______________________________ Preliminary Eval Forms Provided_____

Preliminary Treatment Plan ______________________________ Est. Time ____________ Est. Fee ________

Examination Held With ______________________________

DATES	TREATMENT/NOTES