

WELCOME TO OUR OFFICE

Date \_\_\_\_\_

Patient's name \_\_\_\_\_  
(Last) (First) (M.I.) (Date of Birth)

IF PATIENT IS OVER 18 YEARS OLD:

Home address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City) (State) (Zip)

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City) (State) (Zip)  
 Single  Married  Separated  Divorced  Widowed

IF PATIENT IS UNDER 18 YEARS OLD:

Father's (or Guardian's) Name: \_\_\_\_\_

Home address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City) (State) (Zip)

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City) (State) (Zip)  
 Married  Separated  Divorced  Widowed

Mother's (or Guardian's) Name: \_\_\_\_\_

Home address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City) (State) (Zip)

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City) (State) (Zip)  
 Married  Separated  Divorced  Widowed

Person(s) financially responsible for this account: \_\_\_\_\_  
\_\_\_\_\_

**Insurance Information:**

Do you have dental insurance ( ) Yes ( ) No

Name of insurance company(ies): \_\_\_\_\_  
\_\_\_\_\_

Does your insurance cover orthodontics? ( ) Yes ( ) No

Social security #'s of person(s) covered: \_\_\_\_\_  
& Date of Birth \_\_\_\_\_

Patient's family dentist: \_\_\_\_\_  
(Name) (City)

Date of last visit to the family dentist: \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

AUTHORIZATIONS	
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.	
X _____ Patient/Guardian signature	_____ Date
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.	
X _____ Subscriber signature	_____ Date