WELCOME

To Your Orthodontist!

Tell Us About Your Child

Today's Date____/____/____ Nickname _____

Child's Name _____
LAST FIRST MI

Child's Birthdate ____/____/____ Child's Age _____ ☐ M ☐ F

E-mail Address _____

School _____ Grade: _____

Hobbies/sports: _____

Child's Hm #: (_____)_____ SS # _____

Child's Home Address _____

_____
CITY STATE ZIP

General Information

Who is accompanying the child today?

Name: _____ Relation: _____

Do you have legal custody of this child? ☐Y ☐N

Whom may we thank for referring you? _____

Other siblings/ages: _____

General Dentist: _____

Dentist Ph: (_____)_____ Last Visit Date: _____

Relative or friend not living with you:

Name: _____ Ph: (_____)_____

Address: _____

_____
CITY STATE ZIP

Parent's Information

Who is responsible for account? _____ Marital Status: ☐Single ☐Married ☐Partnered ☐Widowed ☐Divorced ☐Separated

☐ **Father** ☐ Stepfather ☐ Guardian

Name: _____ Birthdate: ___/___/___

Address: (If different than Child's) Hm #: (_____)_____

_____

_____

SS #: _____ DL #: _____

Wk : (_____) _____ Cell #: (_____)_____

Email: _____

Employer: _____ Occupation: _____

Employer Address: _____

_____
CITY STATE ZIP

If you have orthodontic insurance coverage for the child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____
CITY STATE ZIP

Ins. Ph : (_____)_____ Insured's ID #: _____

Group # (Plan, Local or Policy #): _____

☐ **Mother** ☐ Stepmother ☐ Guardian

Name: _____ Birthdate: ___/___/___

Address: (If different than Child's) Hm #: (_____)_____

_____

_____

SS #: _____ DL #: _____

Wk #: (_____)_____ Cell #: (_____)_____

Email: _____

Employer: _____ Occupation: _____

Employer Address: _____

_____
CITY STATE ZIP

If you have orthodontic insurance coverage for the child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____
CITY STATE ZIP

Ins. Ph : (_____)_____ Insured's ID #: _____

Group # (Plan, Local or Policy #): _____

Authorization

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____
SIGNATURE OF PARENT OR GUARDIAN DATE

CONTINUED ON BACK