Patient Information

Patient's Name ____

Address ____
Street City Zip

Home Phone ________________ Cell Phone ________________ Other ________________

Birthdate ________________ Social Security# ________________ Sex M/F

Siblings/Ages ____

Whom may we thank for this referral? ______________________________

School Attending ____

Emergency Contact (Not living with patient) ________________ Phone ________________

Responsible Party

Parent/Guardian Name ____

Address ____
Street City Zip

Social Security# ________________ Birthdate ________________ Relationship to Patient ________

Employer ________________ Occupation ________________ How long? ________

Work Phone ________________ E-Mail Address ______________________________

Marital Status: Single Married Separated Divorced Domestic Partner

Spouse's Name: ______________________________ Relationship to Patient ________________

Employer ________________ Occupation ________________ How long? ________

Social Security# ________________ Birthdate ________________ Work Phone ________________

Dental Insurance Information

Policy Holder's Name ____

Birthdate ______________________________ Social Security ______________________________

Insurance Co. ________________ Group # ________________ Phone # ________________

Insurance Co. Address ____

Privacy Practices Acknowledgement

I have received a copy of the Notice of Privacy Practices of Perfect Smile Orthodontics which includes a total of two (2) pages.

______________________________ ______________________________

Please Print Full Name Parent/Guardian Signature Date