dana orthodontics

Date _____ **Confidential Patient Information** A B C

Patient's Name _____ Birth Date _____

Siblings/Ages _____

Address _____

Home Ph. # _____ **Cell Phone** _____ S.S. #_____

If patient is a minor, give parent's or guardian's name _____

Patient's General Dentist_____

Whom may we thank for referring your to our office _____

Confidential Responsible Party Information

Name_____Marital Status _____

Residence _____

Mailing Address _____

How Long at this address _____ **E-mail Address** _____

Home Phone _____ Work Phone _____ **Cell Phone**_____

Previous Address (if less than 3 yrs.) _____

Social Security # _____ Birth Date _____ Relationship to Patient_____

Employer _____ Occupation _____ # Years Employed _____

Spouse's Name _____ Relationship to Patient_____

Employer _____ Occupation _____ # Years Employed _____

Social Security # _____ Birth Date_____ Work Phone_____

Insurance Information

Policy Holder's Name_____ Social Security #_____

Insurance Company _____Group #_____

Insurance Co. Address _____

Insurance Co. Phone _____Policy Holder's Employer _____

Do you have dual coverage? No _____Yes _____ If yes: (compete information below)

Policy Holder's Name _____ Social Security #_____

Insurance Company _____Group # _____

Insurance Co. Phone _____Policy Holder's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ **Cell Phone** _____Relationship: _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____