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: ___ ☐ Male ☐ Female

E-mail Address: ____________

School: ____________ Grade: ____________

Hobbies/sports: ____________

Child's Home #: (_____)____________ SS #: ____________

Child's Home Address: ____________
Apt / Condo #

____
City State Zip

General Information

Who is accompanying the child today?

Name: ____________ Relation: ____________

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we Thank for referring you?____________

Other siblings/ages: ____________

General Dentist: ____________ Last Visit Date: ____________

Dentist's Phone: (_____)____________

Relative or Friend not living with you:

Name: ____________ Phone: (_____) ____________

Address: ____________

____
City State Zip

Parent's Information

Who is responsible for account? ____________ Parent's Marital Status ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated

☐ **Father** ☐ Step Father ☐ Guardian

Name: ____________ Birthdate:___/___/___

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

____

____

SS #: ____________ DL #: ____________

Wk #: (_____)____________ Ext: ______Cell #: (_____) ____________

Email: ____________

Employer: ____________ Occupation: ____________

Employer's 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

Insurance Phone: (_____)____________ Insured's ID #: ____________

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

☐ **Mother** ☐ Step Mother ☐ Guardian

Name: ____________ Birthdate:___/___/___

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

____

____

SS #: ____________ DL #: ____________

Wk #: (_____)____________ Ext: ______Cell #: (_____) ____________

Email: ____________

Employer: ____________ Occupation: ____________

Employer's Address: ____________

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City State Zip

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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

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