Confidential Patient Information

Date:_____

Patient's Name_____
Last First Middle

Address_____
Street City Province Postal Code

Home Phone_____Birthdate_____Age_____

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

Whom may we thank for referring you to our office?_____

Dentist name_____

Confidential Responsible Party Information

Name_____Marital Status_____
Last First Middle

Residence_____
Street City Province Postal Code

Home Phone_____Cell Phone_____Work Phone_____

Birthdate_____ Relationship to Patient_____

Employer_____Occupation_____

Spouses Name_____Relationship to Patient_____
Last First Middle

Employer_____Occupation_____

Birthdate_____Work Phone_____

Orthodontic Insurance Information

Policy Holder's Name_____Employer_____

Insurance Company _____Group No._____ID_____Lifetime Limit_____ Percentage__

Do you have dual coverage? No_____ Yes_____

Policy Holder's Name_____Employer_____

Insurance Company_____Group No_____ID_____Lifetime Limit_____Percentage___

Emergency Information

Name of nearest relative not living with you_____Phone_____Relationship_____

Signature (Parent's signature if minor)_____