

Patient Information

Date _____ A B C

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Social Security# _____

If patient is a minor, give parent or guardian's name _____
Whom may we thank for referring you to our office? _____
Have any other family members been in Treatment? If so, who: _____

Responsible Party Information

Name _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security# _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security _____ Birthdate _____ Wk Phone _____

Dental Insurance Information

Subscriber's Name _____ Soc. Sec. # _____ Birthdate _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Ins.Co. Phone# _____

Birthdate _____ Do you have dual coverage? Yes _____ No _____ If Yes:

Subscriber's Name _____ Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Ins.Co. Phone# _____

Insurance Authorization and Assignment of Benefits – I authorize release of any information relating to the orthodontic claim. I hereby authorize payment directly to Vecere Orthodontics of any insurance benefits.

Signature: _____

Emergency Information

Name of nearest relative not living with you _____ Phone _____
Complete Address _____

Signature (Parent's signature if minor) _____
Updates (date & initial) _____