Team Demas Orthodontics

ORTHODONTIC PATIENT INFORMATION

Patient ID Number: ____________________________ Age: ____ Birthday: _________ Sex: ________

Patient's Name: ____

Home Address: ____

Home Phone: ____________________ Work Phone: _____________________ SSN: _____________________

PERSON RESPONSIBLE FOR ACCOUNT

Name: ____ Relationship: ____________________________

Home Address: ____

Home Phone: ____________________ Work Phone: _____________________ SSN: _____________________

If minor, other parent's name & work phone #: ____

Is patient covered by insurance for orthodontic treatment? Yes No

Length of time at above address: ___________ Responsible party employer: ____________________________

Occupation: ____________________________ # of Years: _______________ Date of Birth: ______________

Spouse's Name: _____________________________________ Occupation: ____________________________

Parent's marital status: Married Separated Divorced Single

With whom does patient reside? ________________________ Legal Guardian: _________________________

E-mail for patient: ______________________ E-mail for Responsible party: ___________________________

Whom may we thank as your primary referral source? ____

What is the patient's (or parent's) primary concern? ____

Has patient seen another orthodontist? Yes No

Name of previous orthodontist: ____

Family Dentist: _________________________ Last check-up: _____________ Last x-ray: ________________

Number of Siblings: _________ Brothers: _________ Sisters: ___________

Family members treated here: ____

EMERGENCY INFORMATION

Name of nearest relative not living with you: ____

Complete Address: ____

Phone: __________________________________

~~~~~~

I acknowledge that I have received information regarding the Notice of Privacy Practices required by HIPAA.

No interest payment plans are offered. If you would like to arrange payment by this means, a credit check will be necessary.

If orthodontic records are taken and no treatment is started, I understand that I will be financially responsible for the records.

Signature (parent if minor) ____ Date ____________________
~~~~~~