

Orthodontic Associates Patient Information Form

Patients Number: _____

Age: _____

Birth date: _____

Sex: _____

Patient's Name: _____

SSN: _____

Home Address: _____

Home Phone: _____ Work Phone: _____

Employer: _____

Spouse's Name: _____ Work Phone: _____

Spouse's Employer: _____

Have we treated other member's of the Family? Yes No

If so who _____

Is patient covered by insurance for orthodontic treatment? Yes No

Name of Insurance Carrier: _____

Policy Holders Name: _____

Policy Holders Date of Birth: _____

Relationship to Patient: _____

Policy #: _____

Family Dentist: _____

Family Physician: _____

