

# WELCOME TO THE ORTHODONTIST



We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

## 1

### Tell Us About Your Child

Today's Date: \_\_\_\_\_ Nickname: \_\_\_\_\_  
CHILD PREFERS TO BE CALLED

**Child's Name:** \_\_\_\_\_  
LAST FIRST MI

E-mail Address: \_\_\_\_\_ SS#: \_\_\_\_\_

Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_  Male  Female

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Hobbies / Sports: \_\_\_\_\_

Child's Home #: (\_\_\_\_) \_\_\_\_\_

**Child's Home Address:** \_\_\_\_\_  
APT./CONDO #

CITY STATE ZIP

## 4

### Person Responsible For Account

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Billing Address: \_\_\_\_\_  
CITY STATE ZIP

Previous Address: \_\_\_\_\_  
CITY STATE ZIP

Hm #: (\_\_\_\_) \_\_\_\_\_ DL #: \_\_\_\_\_

Cell #: (\_\_\_\_) \_\_\_\_\_ SS #: \_\_\_\_\_

Employer: \_\_\_\_\_ Wk # (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

**Who is responsible for making appointments?**

Name: \_\_\_\_\_

Wk # (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Hm #: \_\_\_\_\_

## 2

### Who is Accompanying Your Child Today?

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Do you have legal custody of this child?  Yes  No

Whom may we Thank for referring you? \_\_\_\_\_

List brothers / sisters with age: \_\_\_\_\_

General Dentist: \_\_\_\_\_

Last Visit Date: \_\_\_\_\_

Parent's Marital Status:  Single  Partnered  Divorced  
 Married  Separated  Widowed

## 3

### Parent: Mother Father Step Parent Guardian

Name: \_\_\_\_\_ Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Email Address: \_\_\_\_\_

Cell #: (\_\_\_\_) \_\_\_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Wk #: (\_\_\_\_) \_\_\_\_\_

SS #: \_\_\_\_\_ DL #: \_\_\_\_\_

**Parent:**  Father  Mother  Step Parent  Guardian

Name: \_\_\_\_\_ Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Email Address: \_\_\_\_\_

Cell #: (\_\_\_\_) \_\_\_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Wk #: (\_\_\_\_) \_\_\_\_\_

SS #: \_\_\_\_\_ DL #: \_\_\_\_\_

## 5

### Primary Orthodontic Insurance

Orthodontic Coverage?  Yes  No

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Policy Owner's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Policy Owner's Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ ID #: \_\_\_\_\_

Policy Owner's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

### Secondary Orthodontic Insurance

Orthodontic Coverage?  Yes  No

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Policy Owner's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Policy Owner's Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ ID #: \_\_\_\_\_

Policy Owner's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

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