



Please take a few minutes to thoroughly complete this form. Thank You.

Date \_\_\_\_\_

### Patient Information

Patient's Name (last, first, MI) \_\_\_\_\_ Preferred Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_

Names and birth dates of siblings \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

### Parent Information

Parent 1 / Guardian (last, first, MI) \_\_\_\_\_

Mailing Address (if different from above) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How long at this address? \_\_\_\_\_ Previous Address (if less than 3 yrs.) \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Carrier (AT&T, Verizon...) \_\_\_\_\_

Work Phone (If we may contact you there) \_\_\_\_\_ Email Address: \_\_\_\_\_

Preferred method of contact for appointments: Email \_\_\_\_\_ Text Message \_\_\_\_\_ Both \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Years Employed \_\_\_\_\_

Date of Birth \_\_\_\_\_ Marital Status: Single \_\_\_ Married \_\_\_ Widowed \_\_\_ Separated \_\_\_ Divorced \_\_\_

Parent 2 / Guardian (last, first, MI) \_\_\_\_\_

Mailing Address (if different from above) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How long at this address? \_\_\_\_\_ Previous Address (if less than 3 yrs.) \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Carrier (AT&T, Verizon...) \_\_\_\_\_

Work Phone (If we may contact you there) \_\_\_\_\_ Email Address: \_\_\_\_\_

Preferred method of contact for appointments: Email \_\_\_\_\_ Text Message \_\_\_\_\_ Both \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Years Employed \_\_\_\_\_

Date of Birth \_\_\_\_\_ Marital Status: Single \_\_\_ Married \_\_\_ Widowed \_\_\_ Separated \_\_\_ Divorced \_\_\_

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## Emergency Information

Name and relationship of nearest emergency contact not living with you \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if patient is a minor) \_\_\_\_\_

## Authorization to Release Information

During the course of treatment it may be necessary to provide treatment information and/or diagnostic records to the family dentist, insurance companies, or other providers. Your signature is required to authorize the release of this information.

Signature \_\_\_\_\_

## Dental Insurance Information

(If you do not have orthodontic coverage, there is no need to provide us with your dental insurance information, nor do we need your medical insurance information.)

Subscriber's Name \_\_\_\_\_

Subscriber's SSN \_\_\_\_\_ ID# \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_ Subscriber's Date of Birth \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ Phone Number \_\_\_\_\_

\* I authorize payment directly to **Thai Orthodontics** of the group insurance benefits otherwise payable to me:

\_\_\_\_\_  
Subscriber's Signature

Do you have dual coverage? Yes No If yes:

Subscriber's Name \_\_\_\_\_

Subscriber's SSN \_\_\_\_\_ ID# \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_ Subscriber's Date of Birth \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ Phone Number \_\_\_\_\_

\* I authorize payment directly to **Thai Orthodontics** of the group insurance benefits otherwise payable to me:

\_\_\_\_\_  
Subscriber's Signature