

# WELCOME

*We would like to welcome you and your child to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation.*

## Patient Information - Child or Teen

Patient's Name \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_  
First Middle Last

Nickname (if preferred) \_\_\_\_\_ Male Female Patient's Home Phone \_\_\_\_\_

Patient's Home Address \_\_\_\_\_ City, State, ZIP \_\_\_\_\_  
Street

Who is filling in this form? Name \_\_\_\_\_  
First Middle Last

Relationship \_\_\_\_\_ Do you have legal custody? YES NO

Patient's General Dentist \_\_\_\_\_ How did you hear about our office? \_\_\_\_\_

Have we treated another member of your family? YES NO If YES, Name \_\_\_\_\_  
First Middle Last

What are the main concerns that you would like orthodontics to accomplish? \_\_\_\_\_

Has your child visited an orthodontist before? YES NO If YES, for what reason? \_\_\_\_\_

Anything you would like to discuss with the doctor in private? YES NO

## Parents Information

Marital Status      Single      Married      Widowed      Divorced      Separated      Domestic Partner

### Father

Father      Step Father      Guardian      Name \_\_\_\_\_  
First Middle Last

Address (if different than child's) \_\_\_\_\_ Birthdate \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ SS # \_\_\_\_\_

Employer \_\_\_\_\_ Employer's Address \_\_\_\_\_ Employer's # \_\_\_\_\_

**If you have insurance coverage for the child, please fill out.**

Insurance Company Name \_\_\_\_\_ Group or plan # \_\_\_\_\_

Insurance Company Phone # \_\_\_\_\_ Insurance Company Address \_\_\_\_\_

### Mother

Mother      Step Mother      Guardian      Name \_\_\_\_\_  
First Middle Last

Address (if different than child's) \_\_\_\_\_ Birthdate \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ SS # \_\_\_\_\_

Employer \_\_\_\_\_ Employer's Address \_\_\_\_\_ Employer's # \_\_\_\_\_

**If you have insurance coverage for the child, please fill out.**

Insurance Company Name \_\_\_\_\_ Group or plan # \_\_\_\_\_

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