

Advance Orthodontics Patient Information

Patient

Name _____ Nickname _____
Last First Middle

PATIENT DOB _____ Social Security # _____

Telephone # _____
Home Work Cell

Address _____
/ Street / Apt City State Zip

School _____ Grade _____ Dentist _____

Emergency contact name & phone number _____

I was referred here by (circle one): patient/parent _____ / dentist _____

-or-
I heard about this practice through (circle one): AdOrthodontics.com / Facebook / Internet Review Site _____

I prefer to receive appointment reminders by (circle one): email / home phone / cell phone / work phone

Email address for appointment reminders _____

I prefer to receive correspondence by (circle one): email / postal mail

Responsible Party

Name _____ Marital status _____
Last First Middle Initial

DOB _____ Social Security # _____ Email address _____

Telephone # _____
Home Work Cell

Address _____
/ Street / Apt City State Zip

If less than 3 years at this address, previous address _____

Relationship to patient _____ Occupation _____ Employer _____

Spouse of Responsible Party (if applicable)

Name _____
Last First Middle Initial

DOB _____ Social Security # _____ Email address _____

Telephone # _____
Home Work Cell

Occupation _____ Employer _____

Dental Insurance

Name of insured _____ Social Security or ID # of insured _____

Insurance company _____ Group # _____ Phone # _____

If you have dual coverage, please advise our staff to discuss current policies.

Please initial next to the following statements:

_____ I have received a copy of this office's *Notice of Privacy Practices*

_____ I consent to a "soft" credit check or credit bureau report (will not affect credit score) so that I may be offered more flexible options for financing treatment.

By signing below, I affirm that the information on this form is correct to the best of my knowledge:

Signature of Responsible Party Printed Name Date