ANGLE ORTHODONTICS

Date_____

Patient's Name_____ Nickname: _____

Date of Birth_____ Age_____Sex_____

Address_____

Home Phone_____School_____Grade_____

Main Concern and reason for visit:_____

Responsible Party Information

Parent's Marital Status (circle one): Married Widowed Divorced Separated Single

Mother's Name_____

Date of Birth_____SS#_____

Employer_____

Occupation_____

Cell #_____

Business Telephone_____Ext_____

E-mail_____

Father's Name_____

Date of Birth_____SS#_____

Employer_____

Occupation_____

Cell # _____

Business Telephone_____Ext_____

E-mail_____

Dental Insurance Information

Subscriber's Name_____SS#_____D/O/B_____

Insurance Company_____Group #_____Employer_____

Do you have dual coverage? If YES, complete the following:

Subscriber's Name_____SS#_____D/O/B_____

Insurance Company_____Group #_____Employer_____

General Information

How did you hear about our practice?_____

Patients Hobbies:_____

Referred by?_____

General Dentist: _____ Date of Last visit?_____