ORTHODONTIC ACQUAINTANCE FORM

PATIENT INFORMATION: TODAY'S DATE: _____

Patient Name: (M) (F) _____ BIRTHDATE: _____
First Middle Last

Present Address: (Street)_____

City: _____ State: _____ Zip Code: _____

Social Security #: _____ Home Phone: _____
(CHILD'S SOCIAL SECURITY)

Cell Phone: _____

Family in Treatment (First & Last Names)

_____

Dentist's Name: _____ Office Name: _____ Phone: _____
(**MUST HAVE DDS NAME)**

Address: _____

Referred by: _____

PARENT INFORMATION:

Mom's full name: _____ Birthdate: _____ SS#: _____

Mom's Address (May use Same): _____Cell Phone: _____

Mom's Employer: _____ Work Phone: _____

Dad's full name: _____ Birthdate: _____ SS#: _____

Dad's Address (May use Same): _____Cell Phone: _____

Dad's Employer: _____ Work Phone: _____

***DENTAL** INSURANCE INFORMATION**:** **If ALL information is not provided, we cannot verify your benefits and you may be responsible for your own insurance submittals. Also, if possible, please give us your card to copy. DO NOT ENTER MEDICAL INFORMATION**
ID #'s are usually the social security number. We must have your ID# to gain access to your ins. info.

***DENTAL** SS#: _____
PRIMARY - Name: _____ Birthday: _____ ID#: _____
Cell Phone # _____
Employer: _____ Work Phone #: _____

Insurance Name **& STATE** _____ Group #: _____

***DENTAL** SS#: _____
SECONDARY - Name: _____ Birthday: _____ ID#: _____
Cell Phone #: _____
Employer: _____ Work Phone #: _____

Insurance Name **& STATE** _____ Group #: _____

We are updating our appointment confirmation system and will need the following information:

FOR APPOINTMENT VERIFICATION: I, _____, authorize the practice to confirm orthodontic appointments via: (Select one).

Home Phone: _____ **E-mail (Address):** _____

Cell Phone: _____ **Text to:** _____

Signature of Parent/Guardian: _____