Patient Information

Patient's Name _____

Address_____

Street City Zip

Home Phone _____Cell Phone _____Other _____

Birthdate _____ Social Security# _____ Sex M/F

Whom may we thank for this referral? _____

School Attending _____

Emergency Contact (Not living with patient) _____ Phone_____

Employer _____ Occupation _____ How long? _____

Work Phone _____E-Mail Address _____

Marital Status: Single Married Separated Divorced Domestic Partner

Spouse's Name: _____Relationship to Patient _____

Employer_____ Occupation_____ How long? _____

Social Security# _____ Birthdate _____ Work Phone_____

Dental Insurance Information

Policy Holder's Name_____

Birthdate _____Social Security_____

Insurance Co._____ Group # _____ Phone #_____

Insurance Co. Address_____

Privacy Practices Acknowledgement

I have received a copy of the Notice of Privacy Practices of Perfect Smile Orthodontics which includes a total of two (2) pages.

_____ _____

Please Print Full Name Signature Date