

PLEASE PRINT

GENERAL PATIENT INFORMATION

NAME: GENDER: DATE: ADDRESS: CITY: STATE: ZIP: HOME PHONE: WORK PHONE: AGE: BIRTHDATE: RESPONSIBLE PARTY: RELATIONSHIP TO RESPONSIBLE PARTY: ADDRESS FOR STATEMENTS (if different from above): CITY: STATE: ZIP: E-MAIL (for appointment reminders): HAS ANY FAMILY MEMBER BEEN A PATIENT HERE? NAME: HAS ANY FAMILY MEMBER WORN BRACES BEFORE? WHO WAS THE ORTHODONTIST? EMERGENCY CONTACT: RELATIONSHIP: PHONE: ADDRESS: CITY: STATE: ZIP:

WHEN WAS THE LAST TIME YOU VISITED A DENTIST OFFICE? DENTIST: HOW MANY WAYS HAVE YOU HEARD OF OUR OFFICE? Friend Name: Yellow Pages Staff Member Family Member Previous Patient Newspaper Your Dentist Television Radio Direct Mail Your Company Insurance Plan

I REALIZE IT MAY BE APPROPRIATE TO UTILIZE A CREDIT REPORT IN DETERMINING A PAYMENT PLAN.

SIGNATURE (Responsible Party): DATE:

IF PATIENT IS AN ADULT:

EMPLOYER: SPOUSE: ADDRESS: EMPLOYER: POSITION: ADDRESS: PHONE NUMBER: () PHONE NUMBER: () SOCIAL SECURITY #: SOCIAL SECURITY #:

IF PATIENT IS A CHILD:

FATHER: MOTHER: EMPLOYER: EMPLOYER: POSITION: POSITION: WORK PHONE NUMBER: () WORK PHONE NUMBER: () SOCIAL SECURITY #: SOCIAL SECURITY #: MARITAL STATUS: MARRIED SEPARATED DIVORCED WIDOWED

ORTHODONTIC INSURANCE INFORMATION (or Pre-paid Plan):

PRIMARY INSURANCE

SECONDARY INSURANCE

POLICY HOLDER: BIRTHDATE: EMPLOYER: INSURANCE COMPANY: INSURANCE PHONE: () ADDRESS: POLICY / GROUP #: EMPLOYEE ID #:

POLICY HOLDER: BIRTHDATE: EMPLOYER: INSURANCE COMPANY: INSURANCE PHONE: () ADDRESS: POLICY / GROUP #: EMPLOYEE ID #:

INFORMATION AND PAYMENT AUTHORIZATION RELEASE:

I AUTHORIZE THE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM AND UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO C. JACK LEE, DMD, INC. OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

SIGNATURE (Responsible Party)

DATE

SIGNATURE (Responsible Party)

DATE