date

Patient Information Form

PATIENT If an adult, please exclude next section

first name | middle | last | nickname | date of birth | age

street | city | state | zip code

social security # | home phone # | cell no#

☐ Male ☐ Female | ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced | school | grade

employer | position/title | work # | years employed

If applicable, spouse's name | middle | last | social security # | date of birth

employer | position/title | work # | years employed

Members of family that are previous patients | If patient is a child, name/age of other siblings

B: BILLING/RESPONSIBLE PARTY If a divorce situation, please complete ALL

MOTHER's first name | middle | last | social security # | date of birth

street (if different from patient) | city | state | zip code

home phone # | cell/work # | e-mail

employer | position/title | work # | years employed

spouse's name (if remarried) | middle | last | social security # | date of birth

employer | position/title | work # | years employed

FATHER's first name | middle | last | social security # | date of birth

street (if different from patient) | city | state | zip code

home phone # | cell/work # | e-mail

employer | position/title | work # | years employed

spouse's name (if remarried) | middle | last | social security # | date of birth

employer | position/title | work # | years employed

INSURANCE

primary dental co. | group # | policy # | subscriber's name | date of birth | employer

secondary dental co. | group # | policy # | subscriber's name | date of birth | employer

OTHER

patient's dentist | last cleaning date | Did the dentist refer you? ☐ Yes ☐ No | If so, why? ie: crowding, etc.

Were you referred? ☐ Yes ☐ No | If yes, by whom? ☐ Friend ☐ Google ☐ Phonebook | If a friend referred, please give us their name so we may thank them!

Pickett ORTHODONTICS LLC