Welcome to our practice! Our goal is to ensure that our patients and their families receive the best possible orthodontic care and service. Please provide the following information about yourself.

**Patient Information:**

Patient's Full Name: ______________________________ Nick Name: ____________

School (if applicable): ______________________________ Birth Date: ____________

Mailing Address: ______________________________________________

Phone: ____________________ Email Address: ____________________

Appointment Reminders: □ Phone (above) □ Email (above) □ Text ____________

Who is your general dentist? ______________________________________

Whom should we thank for referring you to our office? ______________________

Have any of your friends or family members been treated in our office? ______________

Whom should we contact in case of an emergency? (name & phone) ______________________

**Responsible Party Information**: (Please let us know if there is more than one Responsible Party)

Name: ______________________________________________

Relation to patient: ______________________________________

Address (if different from patient): ______________________________

Phone (if different from patient): ______________________________

**Dental/Orthodontic Insurance Information**: (If you have your insurance card with you, please present it to the front desk)

| PRIMARY COVERAGE | SECONDARY COVERAGE |
|---|---|
| Insurance Co: ____________ | Insurance Co: ____________ |
| Phone: ____________ | Phone: ____________ |
| Subscriber Name: ____________ | Subscriber Name: ____________ |
| Employer: ____________ | Employer: ____________ |
| Group #: ____________ | Group #: ____________ |
| Subscriber #: ____________ | Subscriber #: ____________ |
| Subscriber SSN#: ____________ | Subscriber SSN#: ____________ |
| Subscriber Date of Birth: ____________ | Subscriber Date of Birth: ____________ |