Ortho Smiles

CONFIDENTIAL PATIENT INFORMATION-CHILD

Name (Last, First, M.I.) ☐ M ☐ F		**DOB:**
Address:		
Home phone:		**Cell phone:**

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

DADS INFORMATION		
Name: (Last, First, M.I.)		**Birthday:**
Address:		
Home Phone:		**Cell Phone:**
Employer:	**Occupation:**	**Work Phone:**
Email address:		**Social Security No:**

MOMS INFORMATION		
Name: (Last, First, M.I.)		**Birthday:**
Address:		
Home Phone:		**Cell Phone:**
Employer:	**Occupation:**	**Work Phone:**
Email address:		**Social Security No:**

STEP PARENT INFORMATION		
(If applicable)		
Step Dads Name: (First, Last, M.I.)		
Cell Phone:	**Employer:**	**Work Phone:**
Step Moms Name: (First, Last, M.I.)		
Cell Phone:	**Employer:**	**Work Phone:**

I ALSO UNDERSTAND, WHERE APPROPRIATE, CREDIT BUREAU REPORTS MAY BE OBTAINED.

Signature:_____ Date:_____

DENTAL INSURANCE INFORMATION	
Policy holders name:	**SS# or ID#:**
Policy holders home address:	
Birthday:	**Policy holder employer:**
Insurance company:	**Group number:**
Insurance address:	**Insurance phone #:**
Do you have dual coverage? Yes ☐ No ☐	**If yes, please continue below**
2nd policy holders name:	**SS# or ID#:**
2nd policy holders home address:	
Birthday:	**2nd policy holder employer:**
Insurance company:	**Group number:**
Insurance address:	**Insurance phone #:**