PRITCHETT ORTHODONTICS

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Patient's Information

Date _____

Patient's Name _____
Last First Middle

Nickname _____ Social Security # _____

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Age _____ Sex _____

Other family members seen by us: _____

Family Dentist: _____ Referred By: _____

Responsible Party Information

Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Work Phone _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Closest Relative Not Living with Patient _____
Name Phone

In Case of Emergency Please Notify: _____
Name Phone

Insurance Information

Orthodontic Coverage? _____ Yes _____ No

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Co. _____ Group # (Plan, Local, or Policy #) _____

Insurance Co. Address _____ Do you have dual coverage? Yes ___ No ___ If Yes

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Co. _____ Group # (Plan, Local, or Policy #) _____

Insurance Co. Address _____ Employer _____