WELCOME TO PRAIRIE VIEW ORTHODONTICS

OFFICE: A O B DOCTOR: JZ GL DATE: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ Age _____

Date of Birth: _____ Male _____ Female _____ Home Phone: _____

Home Address: _____ City _____ Zip Code: _____

Legal Guardian: _____ Relationship to patient: _____

Home #: _____ Work #: _____ Other # (optional): _____

Email address _____

RESPONSIBLE PARTY INFORMATION

Last Name(mother): _____ First Name(mother): _____

Social Security #: _____ Date of Birth _____ Employer: _____

Home Address: _____ City _____ Zip Code: _____

Last Name (father): _____ First Name (father): _____

Social Security #: _____ Date of Birth _____ Employer: _____

Home Address: _____ City _____ Zip Code: _____

Person(s) Responsible for Account: _____
(Please circle: Mr., Mrs., Mr. & Mrs., Ms.)

INSURANCE INFORMATION

Insured's Name: _____ Insured ID# _____ Date of Birth: _____

Insured's Home # _____ Work # _____ Cell Phone #: _____

Insurance Company _____ Group # _____ Phone #: _____

Insurance Co. Address: _____

Insured Employer: _____ No. Years Employed: _____

I hereby assign insurance benefits to Prairie View Orthodontics: _____

Secondary Insurance:
Insured's Name: _____ Insured ID#: _____ Date of Birth: _____

Insurance Company: _____ Group #: _____ Phone #: _____

Insurance Co. Address: _____

Insured Employer: _____ No. Years Employed: _____

I hereby assign insurance benefits to Prairie View Orthodontics: _____

Family treated in this Office? _____ Name _____

Dentist: _____ Referred by: _____