

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: _____