NOR CAL ORTHODONTICS
Smile With Confidence

PATIENT INFORMATION FORM

PATIENT INFORMATION

Name: _____
(Last)(First)(Middle)

Address: _____
(Street)(Apt. #)

_____
(City)(State)(ZIP)

Birth Date:_____Social Security Number:_____

Employer:_____Occupation:_____No. of Years Employed:_____

Home Phone:_____ Work Phone: _____

Whom may we thank for referring you to our office?_____

Dentist's Name_____ Dentist's Phone:_____
(First)(Last)

NOTE: If you would like us to accurately determine your orthodontic benefits and subsequently bill your insurance as a courtesy for any future treatment, insurance information must be **filled out completely** at the time of your initial examination.

RESPONSIBLE PARTY INFORMATION

Do you have orthodontic insurance? No_____Yes_____Carrier:_____Phone #:_____

Name of Primary Insured:_____Primary's Employer:_____

Primary's Birth Date:_____Primary's Social Security #:_____Group/Plan No:_____

Name: _____
(Last)(First)(Middle)

Address: _____
(Street)(Apt. #)

_____
(City)(State)(ZIP)

Previous Address (if less than 3 years):_____

SS#_____Birth Date:_____Relationship to Patient:_____

Employer:_____Occupation:_____No. of Years Employed:_____

Home Phone:_____Work Phone:_____

Spouse's Name:_____Spouse's Employer:_____

Spouse's Occupation:_____Spouse's Work Phone:_____

EMERGENCY INFORMATION

Name of Nearest Relative Not Living With You:_____
(Last)(First)

Address: _____
(Street)(Apt. #)

_____
(City)(State)(ZIP)

Phone:_____ Relationship: _____

*I understand that credit bureau information may be obtained.