Pattison ORTHODONTICS

Confidential Patient Information

Date_____

Patient's Name_____
Last First Middle

Address_____
Street City State Zip

Home Phone_____ Birthdate_____ Social Security #_____

If patient is a minor, give parent's or guardian's name_____

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

Confidential Responsible Party Information

Name_____ Marital Status_____
Last First Middle

Residence_____ ☐ Own ☐ Rent
Street City State Zip

Mailing Address_____
Street City State Zip

How long at this address_____ Home Phone_____ Work Phone_____

Previous address (if less than 3 years)_____
Street City State Zip

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ # of years employed_____

Spouse's Name_____ Relationship to Patient_____
Last First Middle

Spouse's Employer_____ Occupation_____ # of years employed_____

Spouse's Social Security #_____ Birthdate_____ Work Phone_____

Insurance Information

Policy Holder's Name_____ and Soc. Sec. #_____

Insurance Company_____ Group No._____ Union Local No._____

Insurance Co. Address_____ Insurance Co. Phone_____

Policy Holder's Employer_____

Do you have dual coverage? ☐ No ☐ Yes If yes:

Policy Holder's Name_____ and Soc. Sec. #_____

Insurance Company_____ Group No._____ Union Local No._____

Insurance Co. Address_____ Insurance Co. Phone_____

Policy Holder's Employer_____

Emergency Information

Name of nearest relative not living with you_____

Complete Address_____

Phone_____ Relationship_____

I understand that, where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor)_____ Date_____

Updates (date & initial)_____

CONFIDENTIAL (for record and pretreatment evaluation)