Advance Orthodontics Patient Information

Patient

Name ____
Last First Middle

Name I prefer to be called in this office "____" DOB ____________________

Email address for appointment reminders ____

Telephone # ____
Home Work Cell

Address ____
/ Street / Apt City State Zip

School ____ Grade _____________

Primary Care Dentist (name of doctor or office/practice) ______________________________________

Emergency contact name & phone number ____

I heard about Advance Orthodontics from (check one):

- ❑ A patient or patient's parent: (name & relationship) ______________________________
- ❑ An employee in my dentist's or dental specialist's office: (name) ____________________
- ❑ My primary care dentist or dental specialist: (name) Dr. __________________________
- ❑ Internet: (site) ____
- ❑ Advertisement: (where) ____
- ❑ Other: (specify) ____

Responsible/Billing Party (circle one) Self / Mother / Father / Legal Guardian

Name ____
Last First Middle

Email address ____

Telephone # ____
Home Work Cell

Address ____
/ Street / Apt City State Zip

Occupation ____________________________ Employer ______________________________________

Spouse of Responsible Party, if applicable (circle one) Self / Mother / Father / Legal Guardian

Name ____
Last First Middle

Email address ____

Telephone # ____
Home Work Cell

Occupation __________________________________ Employer ______________________________________

By signing below, I affirm that the information on this form is correct to the best of my knowledge:

Signature of Responsible Party **Printed Name** **Date**

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