Peach Orthodontics

DATE: _____

WELCOME

Our mission is to provide the highest quality orthodontic care in a fun and caring environment.
Please fill out both sides of this form.

PATIENT INFORMATION

Child's Name: _____
LAST FIRST M

Nickname: _____ Home #: ( )_____

Birthday ____/____/____ Age ____ Sex _____

Mother's height: _____ Father's height:_____

Address: _____

City/State/Zip_____

School: _____

Grade: _____

Whom may we thank for referring you?_____

Other family members seen by us? _____

Dentist: _____ Last cleaning:_____

Previous orthodontist: _____

Orthodontic concerns:_____

INSURANCE INFORMATION

I understand that I am responsible for payment for services rendered and also responsible for paying any copayment and deductions that my insurance does not cover. I hereby authorize the dentist to release all information needed to secure payment of benefits.

_____
Signature Date

PRIMARY INSURANCE

Subscribers name:_____

SS#:_____ Birthdate:___/____/____

Insurance company: _____

Address: _____

City/State/Zip_____

Phone #: _____ Group#:_____

FATHER'S INFORMATION

Parent's marital status: _____

__ Father ___ Step-father ___ Guardian

Name: _____

Address: _____

City/State/Zip_____

Home#: ( )_____ Cell#: ( )_____

Social Security #_____

Employer: _____

Occupation: _____ Wk#: ( )_____

MOTHER'S INFORMATION

Parent's marital status: _____

___ Mother ___ Step-mother ___ Guardian

Name: _____

Address: _____

City/State/Zip_____

Home#: ( )_____ Cell#: ( )_____

Social Security #_____

Employer: _____

SECONDARY INSURANCE

Subscribers name:_____

SS#:_____ Birthdate:___/____/____

Insurance company: _____

Address: _____

City/State/Zip_____

Phone #: _____ Group#:_____