

Patient and Responsible Party Information

PATIENT INFORMATION:

FAMILY INFORMATION :(If the patient is under 18)

Name: _____

Mother: _____

Father: _____

DOB ____/____/____

DOB ____/____/____

DOB ____/____/____

Marital Status_____

Marital Status_____

Marital Status_____

S.S. # _____

S.S. # _____

S.S. # _____

Email: _____

Email: _____

Email: _____

Address _____

Address _____

Address _____

City _____

City _____

City _____

State _____ Zip _____

State _____ Zip _____

State _____ Zip _____

Home # _____

Home # _____

Home # _____

School/Employer: _____

Employer: _____

Employer: _____

School / Work # _____

Work # _____

Work # _____

Cell# _____

Cell# _____

Cell # _____

Insurance Co. _____

Insurance Co. _____

Insurance Co. _____

Nearest relative _____ Their # _____

*I hereby authorize release of any information to/ from insurance agencies listed above. I authorize payments directly to Dr. Nicholas S. Ising otherwise payable to me. **I understand that I am responsible for the total cost of orthodontic treatment in case any insurance benefits change during the course of treatment.

Signature (responsible party)

Date

OFFICE USE ONLY:

***I have reviewed all the above information and nothing has changed since my last appointment.**

Signature (responsible party)

Date

***I have reviewed all the above information and nothing has changed since my last appointment.**

Signature (responsible party)

Date