

Welcome!!

Patient and Responsible Party Information

PATIENT INFORMATION:

Name: _____
DOB ____/____/____
S.S. # _____
Email _____
Address _____
City _____
State _____ Zip _____
Home # _____
School/Employer _____
School / Work # _____
Cell# _____
Insurance Co. _____
Nearest relative _____

FAMILY INFORMATION :(If patient is under 18)

Mother: _____ Father: _____
DOB ____/____/____ DOB ____/____/____
S.S. # _____ S.S. # _____
Marital Status _____ Marital Status _____
Address _____ Address _____
City _____ City _____
State _____ Zip _____ State _____ Zip _____
Home # _____ Home # _____
Employer _____ Employer _____
Work # _____ Work # _____
Cell# _____ Cell # _____
Insurance Co. _____ Insurance Co. _____
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