Orthodontic Acquaintance Form

Patient Information

First Name: _____ Last Name: _____

☐ Male
☐ Female

Preferred name: _____ Birth date: ___/___/___

How did you hear about our office? _____ If referred, by who? _____

Special interests, sports, or hobbies: _____

Other family members and their birth dates: _____

Please complete financial information below:

Primary Responsible Party

☐ Self ☐ Mother ☐ Father ☐ Other: _____ Orthodontic insurance? Y / N

First Name: _____ Last Name: _____

Occupation: _____ Employer: _____ How Long: _____

SS# _____ Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Email: _____ Current Address: _____ Apt # ____

Home Phone: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ **if at current less than 3 years** Former Address: _____ Apt # ____

Work Phone: _____ City: _____ State: _____ Zip: _____

Secondary Responsible Party

☐ Self ☐ Mother ☐ Father ☐ Other: _____ Orthodontic insurance? Y / N

First Name: _____ Last Name: _____

Occupation: _____ Employer: _____ How Long: _____

SS# _____ Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Email: _____ Current Address: _____ Apt # ____

Home Phone: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ **if at current less than 3 years** Former Address: _____ Apt # ____

Work Phone: _____ City: _____ State: _____ Zip: _____

If the patient is under the age of 18 and/or is not the financially responsible party of the account, who do they reside with?

The child resides with: ☐ Mother & Father ☐ Father ☐ Mother ☐ Other: _____

- I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence
- I understand that where appropriate, credit bureau reports may be obtained.
- I authorize the dental staff to perform the necessary orthodontic services may be necessary for the initial consultation.
- I authorize that photos taken may be used in journal articles, promotional materials, our website/facebook pages, and are the property of The Best Braces.
- I authorize release of any information relating to any Insurance claim.
- I authorize payment directly, where applicable, to the office of The Best Braces.
- I consent to the dental practice using my cell phone number to contact me regarding appointments, treatment, insurance, and my account.

SIGNATURE (parent or guardian if under 18) _____ **Date:** _____