

Welcome to our office!

Date: _____

Patient Name: _____ I prefer to be called: _____
Last First Middle

Address: _____
Street City State Zip

Birthdate: _____ Social Security#: _____ Email Address: _____

Cell #: _____ Home # (if not cell#): _____ Work #: _____

Employer: _____ Occupation: _____

Marital Status (Circle One): Single Married Divorced Widowed Separated Partnered

Spouse's/Partner's Name: _____ Birthdate: _____

Cell #: _____ Work #: _____ Email Address: _____

Employer: _____ Occupation: _____

Children: _____ Birthdate: _____ M or F Ortho Treatment: Y or N
 _____ Birthdate: _____ M or F Ortho Treatment: Y or N
 _____ Birthdate: _____ M or F Ortho Treatment: Y or N
 _____ Birthdate: _____ M or F Ortho Treatment: Y or N

List any family members who have been or are in treatment in our office: _____

Whom may we thank for referring you to our office? _____

Hobbies: _____

Primary Dental Insurance

Insured's Name: _____ Social Security #: _____
Last First Middle

Relationship to Patient: _____ Birthdate: _____

Insured's Employer: _____ Work #: _____

Insurance Company: _____ Group #: _____

Insurance Phone #: _____

Secondary Dental Insurance

Insured's Name: _____ Social Security #: _____
Last First Middle

Relationship to Patient: _____ Birthdate: _____

Insured's Employer: _____ Work #: _____

Insurance Company: _____ Group #: _____

Insurance Phone #: _____

I authorize Panucci & Jackfert Orthodontics to bill my insurance for any expenses incurred for orthodontic treatment and for payment to be made directly to Panucci & Jackfert Orthodontics. I also give authorization for the office of Panucci & Jackfert Orthodontics to release any necessary information to my insurance for the processing of any orthodontic claim.

 Signature of Patient Date

Emergency Information

Name of nearest relative not living with you: _____

Relationship to patient: _____ Home #: _____ Cell #: _____

Address: _____
Street City State Zip

