

PLEASE PRINT

GENERAL PATIENT INFORMATION

NAME: _____ GENDER: _____ DATE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: () _____ WORK PHONE: () _____ AGE: _____ BIRTHDATE: _____

RESPONSIBLE PARTY: _____ RELATIONSHIP TO RESPONSIBLE PARTY: _____

ADDRESS FOR STATEMENTS (if different from above): _____

CITY: _____ STATE: _____ ZIP: _____ E-MAIL (for appointment reminders): _____

HAS ANY FAMILY MEMBER BEEN A PATIENT HERE? _____ NAME: _____

HAS ANY FAMILY MEMBER WORN BRACES BEFORE? _____ WHO WAS THE ORTHODONTIST? _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: () _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

WHEN WAS THE LAST TIME YOU VISITED A DENTIST OFFICE? _____ DENTIST: _____ Phone: _____

HOW MANY WAYS HAVE YOU HEARD OF OUR OFFICE? Friend Name: _____

- General Dentist Pickron Patient Website / Internet Insurance Plan Pickron Employee Friend
 Yellow Pages Television Radio Direct Mail Your Company Billboard / Office Sign

I REALIZE IT MAY BE APPROPRIATE TO UTILIZE A CREDIT REPORT IN ORDER TO QUALIFY FOR A LOW DOWN PAYMENT PLAN.

SIGNATURE (Responsible Party): _____ DATE: _____

IF PATIENT IS AN ADULT:

EMPLOYER: _____

SPOUSE: _____

ADDRESS: _____

EMPLOYER: _____

POSITION: _____

ADDRESS: _____

PHONE NUMBER: () _____

PHONE NUMBER: () _____

SOCIAL SECURITY #: _____

SOCIAL SECURITY #: _____

IF PATIENT IS A CHILD:

FATHER: _____

MOTHER: _____

EMPLOYER: _____

EMPLOYER: _____

POSITION: _____

POSITION: _____

WORK PHONE NUMBER: () _____

WORK PHONE NUMBER: () _____

SOCIAL SECURITY #: _____

SOCIAL SECURITY #: _____

MARITAL STATUS: MARRIED SEPARATED DIVORCED WIDOWED

ORTHODONTIC INSURANCE INFORMATION (or Pre-paid Plan):

PRIMARY INSURANCE

SECONDARY INSURANCE

POLICY HOLDER: _____

POLICY HOLDER: _____

BIRTHDATE: _____ EMPLOYER: _____

BIRTHDATE: _____ EMPLOYER: _____

INSURANCE COMPANY: _____

INSURANCE COMPANY: _____

INSURANCE PHONE: () _____

INSURANCE PHONE: () _____

ADDRESS: _____

ADDRESS: _____

POLICY / GROUP #: _____

POLICY / GROUP #: _____

EMPLOYEE ID #: _____

EMPLOYEE ID #: _____

INFORMATION AND PAYMENT AUTHORIZATION RELEASE:

I AUTHORIZE THE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM AND UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO PICKRON ORTHODONTIC CARE OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

SIGNATURE (Responsible Party) _____ DATE _____

SIGNATURE (Responsible Party) _____ Date _____