Date _____

Patient Information

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

Name (Last, First, MI) _____ Preferred Name _____

Mailing Address _____ City _____ State _____ Zip _____

How long at this address? _____ Previous Address (if less than 3 yrs.) _____

Home Phone _____ Cell _____ Cell Phone Carrier(AT&T, Verizon..):_____

Work Phone (If we may contact you there) _____ Email Address: _____

Preferred method of contact for appointments: Email _____ Text Message _____ Both _____

Date of Birth _____

Employer _____ Occupation _____ Years Employed _____

Spouse's Name (Last, First, MI) _____

Employer _____ Occupation _____ Years Employed _____

Emergency Information

Name and relationship of nearest relative not living with you _____

Address _____ Phone Number _____

***I understand that where appropriate, credit bureau reports may be obtained.**

Signature _____

Dental Insurance Information

Subscriber's Name _____ Subscriber's SSN _____ ID#_____

Subscriber's Employer _____ Subscriber's Date of Birth _____

Insurance Company _____ Group Number _____

Insurance Company Address _____ Phone Number _____

*** I authorize payment directly to Kiourtsis Orthodontics of the group insurance benefits otherwise payable to me:**

_____
Insured Signature

Do you have dual coverage? Yes No If yes:

Subscriber's Name _____ Subscriber's SSN _____ ID#_____

Subscriber's Employer _____ Subscriber's Date of Birth _____

Insurance Company _____ Group Number _____

Insurance Company Address _____ Phone Number _____

*** I authorize payment directly to Kiourtsis Orthodontics of the group insurance benefits otherwise payable to me:**

_____
Insured Signature

Authorization to Release Information

During the course of treatment it may be necessary to provide treatment information and/or diagnostic records to the family dentist, insurance companies, or other providers. Your signature is required to authorize the release of this information.

Signature : _____