

Please take a few minutes to thoroughly complete this form. Thank You.

Date _____

Patient Information

Patient's Name (last, first, MI) _____ Preferred Name _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____

Names and birth dates of siblings _____

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

Parent Information

Father's Name (last, first, MI) _____

Mailing Address (if different from above) _____ City _____ State _____ Zip _____

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

Home Phone _____ 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 _____

Employer _____ Occupation _____ Years Employed _____

Date of Birth _____

Mother's Name (last, first, MI) _____

Mailing Address (if different from above) _____ City _____ State _____ Zip _____

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

Home Phone _____ 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 _____

Employer _____ Occupation _____ Years Employed _____

Date of Birth _____

Emergency Information

Name and relationship of nearest emergency contact not living with you

Address _____ Phone Number _____

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

Signature (Parent's signature if patient is a minor) _____

(OVER)

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 _____

Dental Insurance Information

(If you do not have orthodontic coverage, there is no need to provide us with your dental insurance information, nor do we need your medical 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:**

Subscriber's 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:**

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