THAI ORTHODONTICS

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

Date _____ Whom may we thank for referring you to our o ce? _____

## Patient Information

Name (Last, First, MI) _____

Mailing Address _____ 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 _____

Date of Birth _____

Employer _____ Occupation _____Years Employed _____

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

Employer _____ Occupation_____ Years Employed_____

## 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 _____

## Dental Insurance Information

(**I**f 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 **Thai Orthodontics** of the group insurance benefits otherwise payable to me:

Subscriber's Signature _____

**Do you have dual coverage? Yes _____ No _____**

**Authorization to Release Information (please initial) Yes_____ No_____**