



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

Date \_\_\_\_\_ Whom may we thank for referring you to our office? \_\_\_\_\_

### Patient Information

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

(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 \_\_\_\_\_

Authorization to Release Information (please initial) Yes \_\_\_\_\_ No \_\_\_\_\_