BIRMINGHAM ORTHODONTICS

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PATIENT INFORMATION – ADULT

(Patient at least 21-years of age)

PATIENT FULL NAME: ______________________ **NICKNAME:** ____________

Date of Birth	Age	Sex	Social Security #	Marital Status	Driver's License #/State
/ /				S M D W	

Best Phone #	Home Phone #	Cell Phone #	Work Phone #
( ) ____ - ______	( ) ____ - ______	( ) ____ - ______	( ) ____ - ______

Address: ______________________ City: ____________ State: ______ Zip: ______

Email address for notifications: ______________________

EMERGENCY CONTACT

FULL NAME: ______________________ **BEST PHONE # (   )** ______ – ______

RELATIONSHIP TO PATIENT: ______________________

Name of Patient's Dentist: ______________________ Dentist Phone # (   ) ______ - ______

Date of Last Cleaning: ____/____/____ Dentist Address: ______________________

Did your dentist refer you to Birmingham Orthodontics for consultation? O Yes O No

Please list any other family members currently in treatment with us:

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

How did you hear about our office? Patient Referral: ______________________

Other Source: O TV O Radio O Internet O Insurance O Yellow Pages O Coupon O School Program O Print Ad O Other:____________

IS PATIENT COVERED BY ORTHODONTIC INSURANCE? O Yes O No

*** IF YES, YOU MUST COMPLETE ALL INSURANCE INFORMATION ON BACK OF THIS FORM ***

Responsible Party Full Name: ______________________ This is the person financially responsible for payments on this account.

Relationship to Patient: O Mother O Father O Grandparent O Aunt/Uncle O Legal Guardian O Other Relationship: ____________

RESPONSIBLE PARTY INFORMATION

Date of Birth	Age	Social Security #	Marital Status	Driver's License #/State
/ /			S M D W	

Best Phone #	Home Phone #	Cell Phone #	Work Phone #
( ) ____ - ______	( ) ____ - ______	( ) ____ - ______	( ) ____ - ______

Address: ______________________ City: ____________ State: ______ Zip: ______

Email address for notifications: ______________________

Responsible Party Employer/City/State	Occupation	Time at Job (Years/Months)
		____/____

FINANCIAL RESPONSIBILITY

This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including reasonable attorney's fees and costs of collection in the event of default.

______________________ ______________

RESPONSIBLE PARTY SIGNATURE **DATE**