Financially Responsible Party Information

Name____
Last First M.I. Marital Status
Residence____
Street City State Zip
Mailing Address____
Street City State Zip
How long at this address? ________ Home Phone _________________ Work Phone__________________
Social Security #:_______________ Birthdate _________________ Relationship to Patient_____________
Employer______________________________ Position ____________________ How long? ___________
Spouse's Name____
Employer______________________________ Position ____________________ How long? ___________
Social Security #:_______________ Birthdate _________________ Work Phone ____________________

Insurance Information

Insured's Name_______________________________________ Insured's Soc. Sec. #:________________
Insured's Employer_____________________________ Group No.____________ Local No.___________
Insurance Company Name & Address____
Do you have Orthodontic coverage? Yes____ No____ If yes, benefit amount: ______________________

Emergency Information

Name of nearest relative not living with you ____
Complete address: ____
Phone: ____________________________________

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

Signature (Parent's signature if minor) ____

Annual Medical History Update

Has there been a change in your health within the last year?....................................... Yes _____ No _____
If yes, please explain ____
Date: _____________________________________ Signature___________________________________

Has there been a change in your health within the last year?....................................... Yes _____ No _____
If yes, please explain ____
Date: _____________________________________ Signature___________________________________

Has there been a change in your health within the last year?....................................... Yes _____ No _____
If yes, please explain ____
Date: _____________________________________ Signature___________________________________

Has there been a change in your health within the last year?....................................... Yes _____ No _____
If yes, please explain ____
Date: _____________________________________ Signature___________________________________

Has there been a change in your health within the last year?....................................... Yes _____ No _____
If yes, please explain ____
Date: _____________________________________ Signature___________________________________