

WELCOME TO



UNIVERSITY ORTHODONTICS

Please fill out this form completely; it is important to your child's orthodontic care. Our goal is to help your child reach and maintain good oral health and a beautiful smile that lasts a lifetime.

Today's Date: _____

Tell Us About Your Child:

Child's Name: _____
LAST FIRST MI
 Nickname: _____ M F
 Birthdate: ___/___/___ Age: ___ SS #: _____
 School: _____ Grade: _____
 Hobbies/Sports: _____
 Child's Home # (_____) _____
 Child's Home Address: _____
 E-mail Address: _____

Person Responsible for Account:

Name: _____ Relation: _____
 Billing Address: _____

CITY STATE ZIP
 Wk #: (_____) _____ Hm #: (_____) _____
 Employer: _____
 How long at current job: ___ Job Title: _____
 SS #: _____ Birthdate: ___/___/___

Who is responsible for making appointments?

Name: _____
 Wk #: (_____) _____ Hm #: (_____) _____

Who is Accompanying Your Child Today?

Name: _____ Relation: _____
 Do you have legal custody of this child? Yes No
 Whom may we thank for referring you? _____
 List other family members seen by us _____

 General Dentist: _____
 Date of last cleaning/visit: _____
 Parent's Marital Status: _____

Primary Orthodontic Insurance

Orthodontic Coverage? yes no
 Insurance Co. Name: _____
 Insurance Co. Address: _____

 Insurance Co. Phone #: (_____) _____
 Group # (plan, local or policy #): _____
 Policy Owner's Name: _____
 Relationship to patient: _____
 Policy Owner's Birthdate: ___/___/___
 Policy Owner's ID #: _____
 Policy Owner's Employer: _____

Parental Information:

Mother Stepmother Guardian other
 Name: _____ Birthdate: ___/___/___
 Wk #: (_____) _____ Hm #: (_____) _____
 Employer: _____
 How long at current job: ___ Job Title: _____
 SS #: _____
 Father Stepfather Guardian other
 Name: _____ Birthdate: ___/___/___
 Wk #: (_____) _____ Hm #: (_____) _____
 Employer: _____
 How long at current job: ___ Job Title: _____
 SS #: _____

Secondary Orthodontic Insurance

Orthodontic Coverage? yes no
 Insurance Co. Name: _____
 Insurance Co. Address: _____

 Insurance Co. Phone #: (_____) _____
 Group # (plan, local or policy #): _____
 Policy Owner's Name: _____
 Relationship to patient: _____
 Policy Owner's Birthdate: ___/___/___
 Policy Owner's ID #: _____
 Policy Owner's Employer: _____

In the event of an emergency, whom should we contact?

His/Her Name: _____
 Relationship: _____
 Wk #: (_____) _____ Hm #: (_____) _____

OFFICE USE ONLY

Insurance Pre-authorization: _____

