

Cory Liss Orthodontics

ORTHODONTIC INFORMATION FORM

Patient Name: _____		
<small>FIRST</small>	<small>MIDDLE</small>	<small>LAST</small>
Date of Birth: _____	Age: _____ yrs.	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
<small>Month/Day/Year</small>		
Address: _____		
<small>CITY</small>		<small>POSTAL CODE</small>
Home #: _____	Work #: _____	
Cell #: _____	E-mail: _____	
General Dentist: _____	Physician: _____	
HOW DID YOU HEAR ABOUT OUR OFFICE? Please tick all that apply.		
Community Magazine: ___	Yellow Pages: ___	Internet: ___ Signage: ___ Dentist: ___ Patient: ___ Staff: ___
If Dentist, Patient, Staff or Other Please Provide Name _____		
I Have a Family Member who was or is a Patient Here _____		

IF PATIENT IS MINOR, PLEASE GIVE PARENT INFORMATION

Mother: _____	Day Contact # _____
Father: _____	Day Contact # _____
Other: _____	Day Contact # _____

RESPONSIBLE PARTY INFORMATION

Name: _____		
<small>FIRST</small>	<small>MIDDLE</small>	<small>LAST</small>
Address: _____		
<small>CITY</small>		<small>POSTAL CODE</small>
Home #: _____	Work #: _____	
Cell #: _____	Relationship to Patient: _____	
Place of Employment: _____	Occupation: _____	

INSURANCE INFORMATION (You will need this information to claim)

Does Your Insurance Benefit Cover Orthodontic Treatment?	Yes	No
(1) Name of Primary Subscriber: _____	Phone #: _____	
Home Address of Subscriber: _____		
Insurance Company Name: _____	Date of Birth: _____	
Group/Policy #: _____	ID #: _____	
(2) Name of Secondary Subscriber: _____	Phone #: _____	
Home Address of Subscriber: _____		
Insurance Company Name: _____	Date of Birth: _____	
Group/Policy #: _____	ID#: _____	