

Cory Liss Orthodontics

ORTHODONTIC INFORMATION FORM

Patient Name: _____
FIRST MIDDLE LAST

Date of Birth: _____ **Age:** _____ yrs. **Gender:** Male Female
Month/Day/Year

Address: _____
CITY POSTAL CODE

Home #: _____ **Work #:** _____
Cell #: _____ **Cell Network:** _____

E-mail: _____

General Dentist: _____ **Physician:** _____

HOW DID YOU HEAR ABOUT OUR OFFICE? Please tick all that apply. Community Magazine: ___
Yellow Pages: ___ Airdrie Echo: ___ 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: _____
FIRST MIDDLE LAST

Address: _____
CITY POSTAL CODE

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 #:** _____
Employers Name: _____ **Phone #:** _____
Insurance Company Name: _____ **Date of Birth:** _____
Group/Policy #: _____ **ID #:** _____
Address (If Subscribers Address is Different Then Above) _____

(2) **Name of Secondary Subscriber:** _____ **Phone #:** _____
Employer Name: _____ **Phone #:** _____
Insurance Company Name: _____ **Date of Birth:** _____
Group/Policy #: _____ **ID#:** _____
Address (If Subscribers Address is Different Then Above) _____