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) ______________________________