KRISHNAN ORTHODONTICS
GENERAL PATIENT INFORMATION

DATE: _______________

FIRST ________________________ MIDDLE ____________________ LAST __________________________________ GENDER: M / F

ADDRESS:____CITY:_________________STATE:_________ZIP:________________________

EMAIL (For Appointment Reminders): ____AGE:______BIRTHDATE: ______/______/______

HOME PHONE: ( )_______________WORK PHONE: ( )___________________________ CELL PHONE: ( )______________________

RESPONSIBLE PARTY:____RELATIONSHIP TO PATIENT:_______________________________

RESP. PARTY SOCIAL SECURITY #:____RESPONSIBLE PARTY DOB:_______________________

ADDRESS FOR STATEMENTS (if different from above):____

CITY:____STATE:__________________ ZIP:______________________________

HAS ANY FAMILY MEMBER BEEN A PATIENT HERE? YES NO NAME: ____

HAS ANY FAMILY MEMBER WORN BRACES BEFORE? YES NO WHO WAS THE ORTHODONTIST?____________________________________

EMERGENCY CONTACT:_______________________________________RELATIONSHIP:___________________PHONE: ( )______________

ADDRESS:____CITY: ________________________STATE:______ZIP:______________

WHEN WAS THE LAST TIME YOU VISITED A DENTIST OFFICE?________DENTIST: ______________________ Phone: _______________

WHO MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE? Name:____

HOW MANY WAYS HAVE YOU HEARD OF CALVERT ORTHODONTICS? ❑ Friend Name:_______________________________________

❑ General Dentist ❑ CO Patient ❑ Website / Internet ❑ Insurance Plan ❑ CO Employee
❑ Yellow Pages ❑ TV / Radio ❑ Direct Mail ❑ Your Company ❑ Billboard / Office Sign

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IF PATIENT IS AN ADULT

EMPLOYER:____

ADDRESS:____

POSITION:____

PHONE NUMBER: ( ) __________________________________

SOCIAL SECURITY #:____________________________________

SPOUSE: ____

EMPLOYER:____

ADDRESS:____

PHONE NUMBER: ( ) __________________________________

SOCIAL SECURITY #:____________________________________

IF PATIENT IS A CHILD

PARENT/LEGAL GUARDIAN:________________________________

EMPLOYER:____

POSITION:____

WORK PHONE NUMBER: ( ) ____________________________

SOCIAL SECURITY #:____________________________________

MARITAL STATUS: ❑MARRIED ❑SEPARATED ❑DIVORCED ❑WIDOWED

If Parent/Legal Guardian is not the financial responsible party *(i.e. grandparent or aunt paying account)*

FINANCIAL RESP. PARTY:________________________________

EMPLOYER:____

POSITION:____

WORK PHONE NUMBER: ( )____________________________

SOCIAL SECURITY #:____________________________________

DATE OF BIRTH:____

PRIMARY ORTHODONTIC INSURANCE OR PRE-PAID PLAN

POLICY HOLDER:____

BIRTHDATE:_____________ EMPLOYER:______________________

INSURANCE COMPANY: ___________________________________

INSURANCE PHONE: ( ) ______________________________

ADDRESS:____

POLICY / GROUP #:_____________________________________

EMPLOYEE ID #:____

SECONDARY INSURANCE

POLICY HOLDER:____

BIRTHDATE:____________EMPLOYER:_________________________

INSURANCE COMPANY: ___________________________________

INSURANCE PHONE: ( ) ______________________________

ADDRESS:____

POLICY / GROUP #:_____________________________________

EMPLOYEE ID #:____

INFORMATION AND PAYMENT AUTHORIZATION RELEASE

I AUTHORIZE THE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM AND UNDERSTAND THAT I AM RESPONSIBE FOR ALL COSTS OF DENTAL TREATMENT AND AUTHORIZE PAYMENT DIRECTLY TO CALVERT ORTHODONTICS OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

____ / ____________

SIGNATURE (Responsible Party) DATE