

Partrick Orthodontics - New Patient Information

Thank you for selecting our orthodontic team! We will strive to provide you with the best possible care. To help us meet all your dental needs, please fill out this form completely in ink. Please ask if you have questions or need assistance.

Personal Information

Patient's Full Name: _____ Preferred Name _____
Address _____
City, State, Zip _____
Telephone: Home _____ Work _____ Cell _____
Date of birth _____ Sex _____ Marital Status _____
Race _____ Occupation _____ Employer _____
Social Security # _____ NC Driver's License # _____
Emergency Contact Name _____ Telephone _____
Is patient a student? If so, what school? _____

*Are you a minor (Under the age of 18)? If so, please have the responsible party fill out the information.

Responsible Party

Responsible Party's Full Name _____
Relationship to Patient _____
Address _____
City, State, Zip _____
Telephone: Home _____ Work _____ Cell _____
Date of birth _____ Occupation _____
Employer _____
Social Security # _____ NC Driver's License # _____
How were you referred to our office? _____

**Please provide your insurance information below in case we need to contact your insurer about a claim. See our financial Policy form for more information about how we handle insurance.*

DENTAL Insurance information

Insured Party's Full Name _____
Relationship to Patient _____
Insured Date of Birth _____ Insured Social Security # _____
Occupation _____ Employer _____
Insurance Company _____
Group # _____ Insurance Company Telephone _____
Effective Date of Insurance _____
Insurance Company Address for Claims _____
