WASATCH ORTHODONTICS

PATIENT INFORMATION

Patient Name______________________________
First middle last

Birthdate: ____/____/____

Home Phone: (______) _______-________

Mailing Address:______________________

____
city State Zip

Dentist: ______________________

Physician: ______________________

Who may we thank for referring you?

____

- [ ] Another patient
- [ ] Website
- [ ] Yellow pages
- [ ] Community magazine mailer

Any medical consideration that we would be informed of? If so explain:

____

____

RESPONSIBLE PARTY INFORMATION

Father's Name______________________ Mother's Name ______________________

Responsible Party Name:______________________________
First middle last

Home Phone: (_____) ______-______ Cell Phone: (_____) ______-_______ Work Phone: (_____) ______-_______

Mailing Address:______________________

____
city State Zip

Relationship to Patient: ______________________

Sex: M F

INSURANCE INFORMATION

Insurance Company:______________________________

Responsible Party Name:______________________________

Insurance Company Address:______________________

Insurance Company Phone: (______) _______-________

____
city State Zip

Employer Name: ______________________

Policy holder name: ______________________________
First middle last

S.S.N.: ______________________

Birthdate: ____/____/____