Fox Valley Orthodontics

PATIENT INFORMATION

Patient Name: _____ ☐ Male ☐ Female

Nickname:_____ Birthdate:____/____/____ Age: _____

Address: _____

City/St/Zip: _____ Home Phone: _____

School: _____ Grade: _____ Sports: _____

Hobbies: _____ Number of Siblings: _____

You were referred by: _____

RESPONSIBLE PARTY INFORMATION

Name: _____ Relationship to Patient:_____

Address: _____

Home #: _____ Cell #:_____

Employer: _____ Work #_____

SSN: _____ Birthdate:_____/_____/_____

Marital Status:_____single _____married_____divorced ____widowed ___separated

Email: _____

SPOUSE/OTHER PARENT/2nd RESPONSIBLE PARTY

Name: _____ Relationship to Patient:_____

Address: _____

Home #: _____ Cell #:_____

Employer: _____ Work #_____

SSN: _____ Birthdate:_____/_____/_____

Marital Status:_____single _____married_____divorced ____widowed __separated

Email: _____

EMERGENCY CONTACT

Name: _____ Relationship to Patient:_____

Phone Number:_____

INSURANCE INFORMATION

PRIMARY

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's SSN: _____ Policy Holder's Birthdate: _____

Insurance Co. Name: _____ Group #: _____ Subscriber ID: _____

Employer: _____

SECONDARY

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's SSN: _____ Policy Holder's Birthdate: _____

Insurance Co. Name: _____ Group #: _____ Subscriber ID: _____

Employer: _____