BRODERICK DUSEK & DELEON ORTHODONTICS

Date: _____
Patient: _____
NP Appt: _____

CHILD PATIENT INFORMATION

First Name: _____ Last Name: _____ Middle Initial: _____
Preferred Name: _____ Date of Birth: _____ Age: _____ Sex: M____F___
Address: _____City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Is patient a full time student? Yes_____ No_____ Name of School Attending: _____

General Dentist: _____ Primary Physician: _____ Phone: _____
Who may we thank for referring you? _____
Have we treated any other family members? _____ Name _____ Relationship_____
Emergency contact: Name _____Phone:_____ Relationship_____

Fathers Name: Dr.____ Mr.____ _____ Address _____
Home Phone: _____ Cell: _____ Work: _____
Date of Birth: _____ Employer: _____

Mothers Name: Dr.____ Ms.____ Mrs. ____ _____ Address: _____
Home Phone: _____Cell: _____Work: _____
Date of Birth: _____ Employer: _____

Person Financially Responsible for Account (Insurance cannot be the responsible party)

Name: Mr.___ Mrs. ___ Mr. & Mrs. _____ **Fathers SS#**____ _____
Mothers SS#_____

If different from father or mother please fill below
Name: Mr.____Mrs._____Mr. & Mrs._____ Relationship to patient: _____
Date of Birth: _____ **SS#**_____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Employer: _____ Address: _____ Phone: _____

Do you have orthodontic insurance: Yes ____ No ____

***As a courtesy to you, we accept assignment of insurance benefits from most insurance companies. However, the balance is your responsibility whether your insurance company pays or not. You must make sure we have your current insurance information on file. Your insurance policy is a contract between you and your insurance company. We are not party to that contract.**

Office Notes: _____
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