VILLAGE ORTHODONTICS

Patient Information Form - Patients Under Age 18

Patient Information

Date Form Completed _____

Name: _____
First Middle Initial Last Preferred Nickname

Date of Birth _____ Gender: ☐ M ☐ F

Address: _____
Street City State Zip Code

Telephone Numbers: _____ _____ _____
Home Mobile Mobile Carrier

Patient E-mail address _____

School Name _____ City _____

Insurance Information

Note: If you would like us to determine your orthodontic benefits and subsequently bill your insurance as a courtesy for any treatment rendered, insurance information must be filled out completely.

Do you have Dental/Orthodontic Insurance? _____

Insurance Company Name _____

Telephone Number _____

Address _____

Group/Plan# _____

Name of Primary Insured _____

Birthdate _____

Primary Soc. Sec/ID # _____

Do you have Secondary Dental/Orthodontic Insurance? _____

Insurance Company Name _____

Telephone Number _____

Address _____

Group/Plan# _____

Name of Secondary Insured _____

Birthdate _____

Secondary Soc. Sec/ID # _____

Responsible Party Information:

Please list the person(s) responsible for this account. For minors under the age of 18, the responsible party is the parent/guardian accompanying the child for treatment and is responsible for signing financial contracts. For separated/divorced parents, the responsible party is the parent who signs the financial contract.

1. Name: _____ Birthdate _____
First Middle Initial Last

Relationship to Patient _____ Soc Sec # _____

Billing Address: _____
Street City State Zip Code

Telephone Numbers: _____ _____ _____ _____
Home Mobile Mobile Carrier Work

E-mail address _____ Occupation _____

Name of Employer _____

Marital Status: ☐ Single ☐ Separated ☐ Divorced ☐ Married Spouse Name _____

2. Name: _____ Birthdate _____
First Middle Initial Last

Relationship to Patient _____ Soc Sec # _____

Billing Address: _____
Street City State Zip Code

Telephone Numbers: _____ _____ _____ _____
Home Mobile Mobile Carrier Work

E-mail address _____ Occupation _____

Name of Employer _____

Marital Status: ☐ Single ☐ Separated ☐ Divorced ☐ Married Spouse Name _____