JESSE N. SCHROEDER DDS MS

ORTHODONTIC PATIENT INFORMATION

Patient's Number:_____ Age:_____Birthdate:_____Sex:____

Patient's Name:_____

Home Address:_____

Street City St Zip Code

Home Phone:_____Work Phone:_____SSN:_____

PERSON RESPONSIBLE FOR ACCOUNT

Name:_____Relation:_____

HomeAddress:_____

Street City St Zip Code

Home Phone:_____Work Phone:_____Cell Phone #:_____

Best phone # to contact parent or patient:_____

Date of Birth:_____ SSN:_____M/F:____ Marital Status:_____

Employer:_____Employer's Phone #:_____

Family Email Address:_____

Please list family members in treatment:_____

Patient's Family Dentist:_____Referred to us by:_____

Please list any serious condition or allergies:_____

Do you have any TMJ problems?:_____

DENTAL INSURANCE INFORMATION

Insurance Co. Name:_____Phone #:_____

Group #:_____Employer:_____

Policy Holder:_____DOB:_____SSN:_____

IF THE PATIENT IS YOUNGER THAN 21 - PLEASE COMPLETE THE FOLLOWING:

Mom's Name:_____Address:_____

Employer:_____Employer's Phone #:_____

Dad's Name:_____Address:_____

Employer:_____Employer's Phone #:_____

I understand that the information that I have given is correct, that it is my responsibility to inform this office of any changes in the patient's medical status and that in order to receive complete information on financial options, it is necessary for me to authorize a credit report. All information will be held in strictest confidence.

_____ _____

Signature Print your name Date

_____ _____

Relationship to Patient SSN