New Patient Information
Adult

Date: _____ **Phone Number:** _____ **Email Address:** _____

Patient Information

Patient's Name:	ID/Driver's License #:	State Issued:
Home Address:	City:	Zip:
Birthdate:	Gender: M F	Age:
Marital Status: Single Married Separated Divorced Widowed		
Dentist Name:		
Employer:	Occupation:	Work #:
Name of nearest relative NOT living with you:		Phone #:
How did you hear about us?		
Have any other family members been treated in this office? Please name them.		

Spouse/ Closest Relative Information

Relationship to Patient:	Relationship to Patien
Name:	Name:
Address:	Address:
Birthdate:	Birthdate:
Employer: Occupation:	Employer: Occupation:
Cell #: Home #:	Cell #: Home #:

Insurance Information

Primary Insurance Company:	Secondary Insurance Company:
Do you have orthodontic coverage? Y N	Do you have orthodontic coverage? Y N
Subscriber Name: Relationship:	Subscriber Name: Relationship:
Subscriber ID or SSN:	Subscriber ID or SSN:
Group #: Group Name:	Group #: Group Name:

Assignment & Release

I certify that I, and /or my dependents(s) have insurance coverage with the above Insurance Company(ies) and assign all the benefits directly to Neibaur Family Orthodontics for services rendered. I fully understand that I am financially responsible for all charges for the rendered treatment whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I further authorize the use of my medical/dental information and disclosure of such information to the Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits, or the payable related services. By this I consent to performing X-rays and necessary treatment.

Signature of Patient/Parent/Guardian/or Personal Representative	Date
Please Print Name	

New Patient Information
Minor

Date: _____ **Responsible Party Email Address:** _____

Patient Information

Patient's Name:		Prefers to be called:		
Hobbies/Activities:				
Home Address:		City:	Zip:	Home #:
Birthdate:	Gender: M F	Age:		
Dentist Name:				
Patient lives with (circle all that apply):	Mother	Father	Grandparent(s)	Other (please specify):
Name of nearest relative NOT living with you:		Phone #:		
How did you hear about us?				
Have any other family members been treated in this office? Please name them.				

Patient's Parent/Guardian Information

Responsible Party #1		Responsible Party #2	
Name:		Name:	
Address:		Address:	
Birthdate:		Birthdate:	
Employer:	Occupation:	Employer:	Occupation:
Cell #:	Home #:	Cell #:	Home #:

Insurance Information

Primary Insurance Company:		Secondary Insurance Company:	
Do you have orthodontic coverage? Y N		Do you have orthodontic coverage? Y N	
Subscriber Name:	Relationship:	Subscriber Name:	Relationship:
Subscriber ID or SSN:		Subscriber ID or SSN:	
Group #:	Group Name:	Group #:	Group Name:

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Signature of Patient/Parent/Guardian/or Personal Representative	Date
Please Print Name	