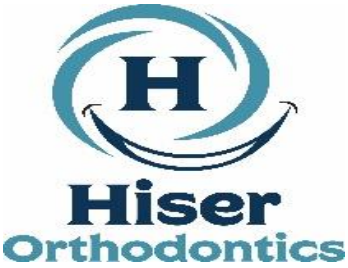

NEW PATIENT INFORMATION

Age Of Patient: _____ **Years Old**
Patient Name: _____
Name Called (Nickname): _____
Birthday: _____/_____/_____ **Gender: Male / Female**
(H / W) Phone: _____ **(C) Phone:** _____
Responsible Party Email: _____
Appointment Reminders Are Sent Through Email & Text Message
Address: _____
City: _____ **State:** _____
Zip Code: _____
Name Of Dentist: _____
Who May We Thank For Referring You? _____

RESPONSIBLE PARTY INFORMATION

Responsible Party: _____
Birthday: _____/_____/_____ **Gender: Male / Female**
Name Of Spouse: _____
(H / W) Phone: _____ **(C) Phone:** _____
Address (If Different From Above): _____
City: _____ **State:** _____
Zip Code: _____
Is This Responsible Party Financially Responsible For Charges? Yes / No
Is This The Primary Person Who Brings The Patient To Appointments? Yes / No

ORTHODONTIC / DENTAL INSURANCE INFORMATION

Policy Holder Name: _____
Birthday: _____/_____/_____ **Group #:** _____
Insurance Company: _____
Insurance Company Phone: _____
ID# or SS#: _____
Employer: _____