

WELCOME

To

Santa Rosa Orthodontics

We would like to welcome you and your child to our office. Our Goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Tell Us About Your Child

Date: _____
Nickname: _____
Child's name: _____
Birthdate: ____/____/____ Age: _____
Child's home address: _____

Gender: _____
Phone number: _____
School: _____
Sports/hobbies: _____
Email address: _____

Who Is Accompanying Your Child Today?

Name: _____ Relation: _____
Do you have legal custody of this child? Y ___ N ___
Whom may we thank for referring you? _____
Other events you have seen us: ___ Sports Team
___ Schools
___ Community Events ___ Website ___ Other
Please Specify: _____
List brothers/sisters with age: _____
General Dentist: _____
Last Visit Date: _____
Parents Marital Status: _____
Spouse Name: _____
Spouse Employer: _____ Job Title: _____

Person Responsible For Account

Name: _____ Relation: _____
Billing Address: _____
Years at current address: _____ Rent: ___ Own: ___
Hm # _____ Wk# _____ Ext. _____
Employer: _____
How long at current job: _____
Job Title: _____
SS#: _____ Birthdate: ____/____/____

Who is Responsible for Making Appointments?

Name: _____ Birthdate: ____/____/____
Wk# _____ Ext. _____ Hm# _____

Primary Orthodontic Insurance

Orthodontic Coverage? Yes ___ No ___

Name: _____
Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Co. Phone #: _____
Group #: _____
Policy Owner's Name: _____
Relationship to Patient: _____
Policy Owner's Birthdate: ____/____/____
ID#: _____
Policy Owner's Employer: _____

Secondary Orthodontic Coverage

Name: _____
Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Co. Phone #: _____
Group #: _____
Policy Owner's Name: _____
Relationship to Patient: _____
Policy Owner's Birthdate: ____/____/____
ID#: _____
Policy Owner's Employer: _____

