

# Periago Orthodontics, LLC

## PATIENT INFORMATION

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Street City State Zip

Home Phone: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_

General Dentist: \_\_\_\_\_

How did you hear about our offi \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION

Name: \_\_\_\_\_  
Last First Middle Marital Status

Residence: \_\_\_\_\_  
Street City State Zip

Mailing address: \_\_\_\_\_  
Street City State Zip

How long at this address \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Previous Address (if less than 3 years): \_\_\_\_\_  
Street City State Zip

SS#: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ No. Years Employed: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Last First Middle

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ No. Years Employed: \_\_\_\_\_

SS#: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## INSURANCE INFORMATION

Insured's Name: \_\_\_\_\_ Insured's SS or ID #: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Group #: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_  
Street City State Zip

Insured's Employer: \_\_\_\_\_

Do you have dual coverage? Yes No If yes:

Insured's Name: \_\_\_\_\_ Insured's SS#: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Group #: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_  
Street City State Zip

Insured's Employer: \_\_\_\_\_

## EMERGENCY INFORMATION

Name of nearest relative not living with you: \_\_\_\_\_

Complete Address \_\_\_\_\_  
Street City State Zip

Phone: \_\_\_\_\_

Initials (Parent/Guardian if minor): \_\_\_\_\_

