SAWYER ORTHODONTICS

Dr. Amy Smith Sawyer

PATIENT INFORMATION for PATIENTS UNDER 18 YEARS OF AGE

Date:_____

Name:_____
Last First Middle

Address_____
Street City Zip

Nickname_____Birthdate_____Social Security #_____
School_____Sports/Hobbies_____
Parent/Guardian(s)_____
Siblings (names, ages)_____
Other family members treated at our office_____
Who may we thank for referring you to our office?_____

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle

Address_____
Street City Zip

How long at this address?_____Own or Rent?_____
Home Phone_____Work Phone_____
Cell/Other Phone_____Email Address_____
Social Security#_____Birthdate_____Relationship to Patient_____
Employer_____Occupation_____
Spouse's Name_____Spouse's Phone_____
Best number to contact you? (circle one) Home Work Cell/Other

DENTAL INSURANCE INFORMATION

**Please provide all information below. It is necessary to verify your orthodontic benefits.*

Policy Holder's Name_____Policy Holder's SSN#_____
Policy Holder's DOB_____Insurance Company_____
Member ID_____Group No._____
Insurance Co. Address_____
Insurance Co. Phone _____
Policy Holder's Address_____

EMERGENCY CONTACT

Name_____Phone _____

I understand that, where appropriate, credit bureau reports may be obtained. (Please note: Credit reports obtained by our office have no effect on credit scores and will not appear on credit reports.)

Parent/Guardian Signature_____
Updates (date & initial)_____