New Patient Information

Date: ____________________ **Cell Phone:** ________________________ **Email Address:** ________________________________

Patient Information			
Patient's Name:	ID/Driver's License #:		State Issued:
Home Address:	City:	Zip:	Home #:
Birthdate:	Gender: M F Age:	Marital Status: Married	Single Minor
Dentist Name:			
Employer:	Occupation:	Phone #:	
Address:			
Name of the nearest relative NOT living with you:		Phone #:	
How did you hear about us?			

Minor Patient's Parent/Guardian Information			
Mother's Information		Father's Information	
Name:	SS#:	Name:	SS#:
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 #:		Subscriber ID #:	
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	