BRACES
Designer Smiles
BY BENTON

PATIENT INFORMATION

WELCOME TO OUR OFFICE!

Date:______________
Patient's Name:____
Last *First* *Middle*
Address:____
Street *City* *State* *Zip*
Home Phone:__________________**Birth Date:**_________________**Social Security #:**________________
If patient is minor, give parent or guardian's name:________________________________
Patient:_______________________________**Responsible Party:**_______________________________
Email Address *Email Address*
Names & ages of any other children in the family:

___________________________ ____________________________ ______________________________
___________________________ ____________________________ ______________________________

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*
Social Security #:_______________**Birth Date:**______________**Relationship to Patient:**____________
Employer:__________________**Occupation:**____________________**No. Years Employed:**____________
Spouse's Name:____________________________________**Relationship to Patient:**________________
Last *First* *Middle*
Spouse's Employer:_______________**Occupation:**_________________**No. Years Employed:**_________
Spouse's Social Security #:_____________________**Spouse's Birth Date:**________________________

INSURANCE INFORMATION

Insured's Name:_________________**DOB**_____________**Insured's Soc. Sec. #:**___________________
Insurance Company_______________________**Group #:**________________**Local No.**_______________
Insurance Co. Address:____
Do you have dual coverage? Yes:______**No:**_______**If yes, please continue:**____________________
Insured's Name:___________________**DOB**______________**Insured's Soc. Sec. #:**________________
Insurance Company:________________________**Group #:**_______________**Local No.**_____________
Insurance Co. Address:____
Insured's Employer:____

Emergency Information

Name of nearest relative not living with you:____________________________________
Complete Address:____
Phone #:________________________________**Relationship to Patient:**___________________________

Signature (Parent's signature, if minor):______________________________**Date:**__________________
I understand that where appropriate, credit bureau reports may be obtained.

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