THAI AND KIOURTSIS ORTHODONTICS

Please take a few minutes to thoroughly complete this form. Thank You.

Date _____

Patient Information

Patient's Name (last, first, MI) _____ Preferred Name _____

Address _____ City _____ State _____Zip _____

Date of Birth _____
Names and birth dates of siblings _____
Whom may we thank for referring you to our office? _____

Parent Information

Father's Name (last, first, MI) _____

Mailing Address (if different from above)_____ City _____ State ___ Zip_____

How long at this address? _____ Previous Address (if less than 3 yrs.) _____

Home Phone _____ Cell Phone # _____ Carrier (AT&T, Verizon...) _____

Work Phone (If we may contact you there) _____ Email Address: _____

Preferred method of contact for appointments: Email _____ Text Message _____ Both _____

Employer _____ Occupation _____ Years Employed _____

Date of Birth _____ Marital Status: Single___Married ___Widowed___Separated___Divorced __

Mother's Name (last, first, MI) _____

Mailing Address (if different from above)_____ City _____ State ___ Zip_____

How long at this address? _____ Previous Address (if less than 3 yrs.) _____

Home Phone _____ Cell Phone # _____ Carrier (AT&T, Verizon...) _____

Work Phone (If we may contact you there) _____ Email Address: _____

Preferred method of contact for appointments: Email _____ Text Message _____ Both _____

Employer _____ Occupation _____ Years Employed _____

Date of Birth _____ Marital Status: Single___Married ___Widowed___Separated___Divorced __

Emergency Information

Name **and** relationship of nearest emergency contact not living with you _____

Address _____Phone Number _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if patient is a minor) _____

Authorization to Release Information

During the course of treatment it may be necessary to provide treatment information and/or diagnostic records to the family dentist, insurance companies, or other providers. Your signature is required to authorize the release of this information.

Signature _____

Dental Insurance Information

(**If** you do not have orthodontic coverage, there is no need to provide us with your dental insurance information, nor do we need your medical insurance information.)

Subscriber's Name _____

Subscriber's SSN _____ ID#_____

Subscriber's Employer _____Subscriber's Date of Birth _____

Insurance Company _____ Group Number _____

Insurance Company Address _____ Phone Number _____

*** I authorize payment directly to Kiourtsis Orthodontics of the group insurance benefits otherwise payable to me:**

_____

Subscriber's Signature

Do you have dual coverage? Yes No If yes:

Subscriber's Name _____

Subscriber's SSN _____ ID#_____

Subscriber's Employer _____Subscriber's Date of Birth _____

Insurance Company _____ Group Number _____

Insurance Company Address _____ Phone Number _____

*** I authorize payment directly to Kiourtsis Orthodontics of the group insurance benefits otherwise payable to me:**

_____

Subscriber's Signature