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