IDC PATIENT INFORMATION

WELCOME: *Thank you for selecting Inland Dental Center for your orthodontic needs. This information is necessary for our files and will be considered CONFIDENTIAL.*

Date_____ Acct. # _____

Patient's Name _____
First Initial Last

_____
Nickname Birthdate Age

Address_____ How Long _____

City_____ Zip _____ Phone ( ) _____

General Dentist _____ Physician _____ Referred by_____

Father's Name _____ Birthdate _____ Occupation _____

Address_____ City _____ Zip _____

Phone ( )_____ Social Security #_____

Employed by _____ How Long _____ Work Phone ( ) _____

Business Address _____ City _____

Mother's Name _____ Birthdate _____ Occupation _____

Address_____ City _____ Zip _____

Phone ( )_____ Social Security #_____

Employed by _____ How Long _____ Work Phone ( ) _____

Business Address _____ City _____

Hobbies_____ Have we treated other family members?_____

Nearest Relative _____ Relationship _____

Address _____ Phone ( ) _____

DENTAL INSURANCE INFORMATION

Father's Insurance Company _____ Phone ( ) _____

Mother's Insurance Company_____ Phone ( ) _____

Are you covered by any additional Dental Insurance? YES____ NO____ IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insurance company _____

_____
Name of Insured Birthdate

_____
Relationship Social Security Number