Youth Patient Form

Date_____

Patient's Legal Name_____ Preferred Name_____

DOB_____ Gender_____ School/Grade_____

Hobbies/Interests_____

Referred By_____ General Dentist_____

Past or Present Family Members in Treatment _____

Have you Consulted an Orthodontist Before?_____

PARENT/GUARDIAN INFORMATION

Mother's Name_____ DOB_____

E-Mail Address_____ Marital Status/Spouse's Name_____

Address_____ Phone _____Cell phone_____

Employer_____ Occupation_____

Father's Name_____ DOB_____

E-Mail Address_____ Marital Status/Spouse's Name_____

Address_____ Phone_____

Employer_____ Occupation _____

DENTAL INSURANCE INFORMATION

Subscriber's Name_____ DOB_____

Address_____ Phone_____

Employer_____

Insurance Company_____ Phone_____

Group Number_____ Subscriber ID/SS#_____

Signature_____ Date_____

(Parent/Legal Guardian)

Signature_____ Date_____

(Parent/Legal Guardian)