SMILES OF LOMBARD
PATIENT INFORMATION FORM

PATIENT INFORMATION

Name: ______________________________ Gender: __________

Address: ______________________________ City: __________ State: ____ Zip: ________

Birthdate: ______________ Age: ______ SS #: ______________ Occupation: ______________

Employer: ______________________________ # of Years Employed: ______________

Work #: ______________ Home #: ______________ Cell #: ______________

E-Mail Address: ______________________________

Hobbies/Sports: ______________________________

School: ______________________________ City of School: ______________

Other family members seen by us (provide age): ______________________________

Sibling(s) not listed above (current or treated elsewhere): ______________________________

Whom may we THANK for referring you to our office? ______________________________

Dentist's Name: ______________ City: ______________ Ph #: ______________ Last Visit : ________

Responsible Party's Signature: ______________________________ **Today's Date:** ______________

INSURANCE INFORMATION

INSURANCE: If you would like us to accurately determine your orthodontic benefits and subsequently bill your insurance AS A COURTESY for any future treatment, insurance information must be filled out completely **BEFORE** you come in for your initial appointment. (Note: Orthodontics is Dental and TMJ is Medical)

Do you have Orthodontic Insurance? ____ No ___ Yes Carrier: ______________ Member ID #: ______________

Carrier Address: ______________________________ Carrier Ph #: ______________

Name of Primary Insured: ______________ Primary Birthdate: __________ Primary SS#: ______________

Do you have Secondary Insurance? ____ No ___ Yes Carrier: ______________ Member ID #: ______________

Carrier Address: ______________________________ Carrier Ph #: ______________

Name of Secondary Insured: ______________ Secondary Birthdate: ________ Secondary SS#: ______________

RESPONSIBLE PARTY INFORMATION

NOTE: If separated/divorced the responsible party of the child is the custodial parent. The person responsible for account and signing contract is the ***only person*** legally able to acquire information regarding patient. If responsible party has legal custody of a person under 18 and the relationship to the person is not mother/father, please provide information below.

Name: ______________________________ Relationship to Patient: ______________

Employer: ______________ Occupation: ______________ # of Years Employed: ______________

Home #: ______________ Cell #: __________ SS#: ______________ Birthdate: ______________

Billing Address: ______________________________

Previous Address (if less than 3 years): ______________________________

Mother's Information: ☐Step Mother ☐Guardian Name: ______________ Birthdate: ______________

SS#: ______________ Home #: ______________ Cell #: ______________

Father's Information: ☐Step Father ☐Guardian Name: ______________ Birthdate: ______________

SS#: ______________ Home #: ______________ Cell #: ______________

Who is Reponsible for Making Appointments? Name: ______________________________

Relationship to Patient: ______________ Home #: ______________ Cell #: ______________

If you are **NOT** the *Patient* or the *Responsible Party* filling out this form, please provide:

Name: ______________________________ Relationship to Patient: ______________

Address: ______________ Home #: ______________ Cell #: ______________

Signature: ______________________________ **Today's Date:** ______________

EMERGENCY INFORMATION

Primary Physician's Name: ______________________________ Phone #: ______________

Physician's Address: ______________________________ City: ______________

Name of nearest relative NOT living with you: ______________________________

Address: ______________________________

Home #: ______________ Work #: ______________ Cell #: ______________