

INFORMATION FORM

Please Print

Date _____ Patients Full Name _____

Patient or Parent that Authorized Treatment:

Parents Full Name _____
Birthdate _____ Social Security Number _____
Present Street Address _____ years there _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Email address _____
Present Employer _____ years there _____
Employer Address _____
City _____ State _____ Zip _____ Phone _____
Position or Title _____

Second Parent

Parents Full Name _____
Birthdate _____ Social Security Number _____
Present Street Address _____ years there _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Email Address _____
Present Employer _____ years there _____
Employer Address _____
City _____ State _____ Zip _____ Phone _____
Position or Title _____

We are sorry that we cannot accept divorce decrees as assignments of responsibility for a child's orthodontic bills. The parent accompanying the child should pay for the services and seek any reimbursement from the other parent. To the best of my knowledge the above information is complete and correct. I give my permission for any photographs, x-rays, or study models to be used for displays at scientific meetings, presentations, and publications of a scientific nature or for study group purposes to further the art and science of orthodontics. I the undersigned agree to pay for attorney fees and other costs of collecting in the event it becomes necessary to use attorney services to secure payment of this account. I authorize the release of any information relating to treatment to the insurance company and their payment directly to the orthodontist. I understand that I am responsible for all costs of treatment.

Date signature of patient or parent or guardian if patient is a minor