

ORTHODONTIC EXAMINATION QUESTIONNAIRE

Date _____

Patient's Name _____ Nickname _____ Birthdate _____ Age _____ Sex _____

Address _____ City _____ State _____ Zip _____

School _____ Grade _____ Weight _____ Height _____

RESPONSIBLE PARTY INFORMATION

Father's Full Name _____ Birthdate _____ Age _____

Address _____ How Long? _____

City _____ State _____ Zip _____

Previous Address (if less than 3 years) _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employed By _____ Occupation _____ How Long? _____

Social Security Number _____ / _____ / _____ Marital Status _____

Email Address _____

Is orthodontic insurance a benefit of this company? _____ Group # _____

INSURANCE COMPANY _____

ADDRESS _____ PHONE NUMBER _____

Mother's Full Name _____ Birthdate _____ Age _____

Address _____ How Long? _____

City _____ State _____ Zip _____

Previous Address (if less than 3 years) _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employed By _____ Occupation _____ How Long? _____

Social Security Number _____ / _____ / _____ Marital Status _____

Email Address _____

Is orthodontic insurance a benefit of this company? _____ Group # _____

INSURANCE COMPANY _____

ADDRESS _____ PHONE NUMBER _____

Name and phone number of nearest relative not living with you: _____

Child Lives With _____ Names and ages of other children in the family? _____

Who may we thank for this referral? _____

