

PATIENT INFORMATION FORM

PATIENT INFORMATION

Name _____ Nickname _____ M/F Age _____ Birthdate _____
 Street Address _____
 City _____ State _____ Zip _____ Phone _____
 Name & Age of Siblings _____
 Patient's School _____
 If patient is a college student, please provide a residence address _____

 Whom may we thank for referring you to our office? _____

PARENT'S/GUARDIAN'S INFORMATION

Father's Name _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____
 Mother's Name _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____

RESPONSIBLE PARTY INFORMATION

Person responsible for account _____
 Billing address _____
 Relationship to patient _____

EMERGENCY CONTACT

Name _____ Relationship _____
 Complete Address _____
 Home Phone _____ Work Phone _____

The office of Dr. Burkland will be happy to process your orthodontic claims.

To successfully process your claims, all of the following information is necessary.

If you do not have all of the required information we suggest you contact your Human Resources Representative and they can help you with any missing information.

DENTAL INSURANCE INFORMATION

Primary Insured's Name _____	Insured's Date of Birth _____
Insurance Co. _____	Soc. Sec. No. _____
Insurance Co. Address _____	Phone _____
Insured's Employer _____	Group No. _____

I hereby authorize release of any information relating to my insurance.

Signature: _____ Date _____

I hereby authorize payment of insurance benefits directly to the orthodontist.

Signature: _____ Date _____

Dual Insurance (if applicable)

Secondary Insured's Name _____	Insured's Date of Birth _____
Insurance Co. _____	Soc. Sec. No. _____
Insurance Co. Address _____	Phone _____
Insured's Employer _____	Group No. _____