HOLMES PALMER ORTHODONTICS

Today's Date: _____

Please update the following information for our records and return completed form to the front desk.

Patient's Full Name: _____

Patient's DOB: _____Patient's Preferred Name:_____

Patient's Address: _____
Street Name/House Number/Apt Number

_____
City *State* *Zip*

Mom's Cell: _____ **Dad's Cell:_____**

Home Phone #: _____ **Best # _____**
(land line) (*to be reached during normal business hours)*

E-Mail Address: _____

Primary Dental Insurance Information

Cardholder Name*:* _____ DOB*:*_____

Employer:_____ Insurance Company: _____

ID or SSN: _____Telephone #:_____ Relationship to Patient:_____

Secondary Dental Insurance Information

Cardholder Name: _____ DOB:_____

Employer:_____ Insurance Company: _____

ID or SSN: _____ Telephone #:_____ Relationship to Patient:_____

Any Health Changes?: Yes_____ No_____
If yes, explain:_____
Any Allergies or Drug sensitivity? _____

Name of your General Dentist and Date of Last Cleaning:

Dentist: _____ Last Cleaning: _____
(NOT Orthodontist)

What school does patient attend? _____

Signature of Parent/Guardian:_____

Printed Name:_____

Relationship to patient:_____

Updated 1.4.21/KP