

# Wright Orthodontics

WELCOME TO OUR OFFICE

## {DR. WRIGHT'S CHILD INFORMATION FORM}

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Name preference \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Father's Name \_\_\_\_\_ SS # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ SS # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Person Responsible for Account \_\_\_\_\_

Emergency contact not living with you \_\_\_\_\_ Phone # \_\_\_\_\_

General Dentist \_\_\_\_\_ Date of last visit \_\_\_\_\_

Is there Orthodontic Insurance? \_\_\_\_\_ Policy # \_\_\_\_\_

Primary Insurance Company Name \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_

Name of Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_

Secondary Insurance Company Name \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_ Policy # \_\_\_\_\_

Name of Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_

**This office reserves the right to verify the credit status of potential patients and or parents prior to extending credit for treatment fees and may, at the discretion of this office, use the services of a credit reporting service.**

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date