Date ____________________

PATIENT INFORMATION

Patient Name ____________________ ____________________ ____________________ ______
Last First Middle Sex

Address ____

Phone # ____________________ Birthdate ____________ email: ____________________

Is patient a minor? ❑ Yes ❑ No School ____________________ Grade ____________

(If yes) Parents/Guardians Names ____

Are any family members patients in our office? ____

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

RESPONSIBLE PARTY INFORMATION

Patient/Parent ____________________ ____________________ ____________________ ____________
Last First Middle Marital Status

Residence ____

Mailing Address ____

How long at this address __________ Phone # __________ Work # __________ email: __________

S.S. # ____________________ Birthdate ____________ Relationship to patient ____________

Employer ____________________ Occupation ____________________ Yrs. Employed ____________

Orthodontic Insurance Company ____

Group # ____________________ ID # ____________________ SS# ____________________

Billing Address ____ Phone # ____________

Spouse/Other Parent ____________________ ____________________ ____________________ ____________
Last First Middle Marital Status

Residence ____

Mailing Address ____

How long at this address __________ Phone # __________ Work # __________ email: __________

S.S. # ____________________ Birthdate ____________ Relationship to patient ____________

Employer ____________________ Occupation ____________________ Yrs. Employed ____________

Orthodontic Insurance Company ____

Group # ____________________ ID # ____________________ SS# ____________________

Billing Address ____ Phone # ____________

AUTHORIZATION

I hereby authorize Joseph A. Catania, D.D.S. to perform such diagnostic and therapeutic procedures as may be necessary for proper orthodontic care. I understand that I am responsible for all costs of dental treatment. I authorize release of any information to my insurance company and I hereby authorize payment directly to Joseph A. Catania, D.D.S. of the group insurance benefits otherwise payable to me. I understand that where appropriate, credit bureau reports my be obtained.

SIGNATURE OF RESPONSIBLE PARTY

X ____ Date ____________________

❑ Adult Patient ❑ Parent ❑ Guardian

FOR OFFICE USE ONLY

Clinical Exam Notes

Exam Date ______________________

Doctor ______________ Asst ______________

Patient Name ______________________

Parent/Pt Concern ______________________

Present at Exam ______________________

Dentist Concern ______________________

Dentition

R | L

Findings

Recommendations