

☐ Parent

☐ Adult Patient

☐ Guardian

Date		
1000 0000 0000 000 000 000 000 000 000		

Last	PATIENT INFORMATION Patient Name				
Phone # Birthdate email: Grade	Last	First	Mid	ddle Sex	
Is patient a minor?	Address				
(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 attent/Parent Last First Middle Marital Status Residence Mailing Address How long at this address Phone # Work # email: Employer Occupation Yrs. Employed Orthodontic Insurance Company Group # ID # SS# Billing Address How long at this address Phone # Middle Marital Status Residence Mailing Address Phone # Relationship to patient Employer SS# Billing Address Phone # SS# Residence Mailing Address How long at this address Phone # Middle Marital Status Residence Mailing Address How long at this address Phone # Relationship to patient Employer Occupation Yrs. Employed Orthodontic Insurance Company Group # Relationship to patient Employer Occupation Yrs. Employed Orthodontic Insurance Company Group # ID # SS# Billing Address Phone # SS# Billing Address Phone # SS#	Phone #	Birthdate	email:		
re any family members patients in our office? ###################################	Is patient a minor? ☐ Yes	No School		Grade	
Thom may we thank for referring you to our office? The sponsible party information attent/Parent The sest of the	(If yes) Parents/Guardians Na	nes			
ESPONSIBLE PARTY INFORMATION atient/Parent	e any family members patients in our	office?			
Last First Middle Marital Status	nom may we thank for referring you t	our office?			
Last First Middle Marital Status Residence	ESPONSIBLE PARTY INFO	RMATION			
Residence	itient/Parent		Middle	Marital Status	
Mailing Address Phone # Work # email: S.S. # Birthdate Relationship to patient Occupation Yrs. Employed Orthodontic Insurance Company ID # SS# Phone # Phone # Ouuse/Other Parent Last First Middle Marital State		80 883503		Marital Status	
How long at this addressPhone #Work #email:					
S.S. # Birthdate Relationship to patient Employer Occupation Yrs. Employed Orthodontic Insurance Company Group # ID # SS# Billing Address Phone # Middle Marital S Residence Mailing Address Phone # Work # email: S.S. # Birthdate Relationship to patient Employer Occupation Yrs. Employed Orthodontic Insurance Company Group # ID # SS# Billing Address Phone # SS# Billing Address Phone # Phone # Proceedings Phone # Phone # Procedure Phone # Pho				email:	
Employer	72				
Orthodontic Insurance Company Group #					
Group #					
Billing Address					
Last First Middle Marital S Residence					
Mailing Address Phone # Work # email: S.S. # Birthdate Personal Processing Proc			Phone #		
Mailing Address	oouse/Other ParentLa	t First	Middle	Marital Status	
How long at this address	Residence				
S.S. #	Mailing Address				
EmployerOccupationYrs. Employed Orthodontic Insurance Company Group #ID #SS# Billing AddressPhone #	How long at this address	Phone #	Work #	email:	
Orthodontic Insurance Company	S.S. #	Birthdate	Relationship to patient _		
Orthodontic Insurance Company ID # SS# Billing Address Phone #	Employer	Occupation	Yrs. Empl	Yrs. Employed	
Billing Address Phone #	Orthodontic Insurance Compa	ny			
Billing Address Phone #	Group #	ID #	SS#		
AUTHORIZATION dereby authorize Joseph A. Catania, D.D.S. to perform such diagnostic and therapeutic procedures as may be necessary for thodontic care. I understand that I am responsible for all costs of dental treatment. I authorize release of any information to me surance company and I hereby authorize payment directly to Joseph A. Catania, D.D.S. of the group insurance benefits other syable to me. I understand that where appropriate, credit bureau reports my be obtained. GNATURE OF RESPONSIBLE PARTY	ereby authorize Joseph A. Catania, I thodontic care. I understand that I an surance company and I hereby autho lyable to me. I understand that where	AUTHORIZATION.D.S. to perform such diagnostic a responsible for all costs of dental rize payment directly to Joseph A. appropriate, credit bureau reports	TION and therapeutic procedures as mattreatment. I authorize release of Catania, D.D.S. of the group ins	may be necessary for proportion of any information to my	
Date	GIVATORE OF RESPONSIBLE FAR	N.	Date		

Clinical Exam Notes

Exam Date	Doctor	Asst			
Patient Name	Parent/Pt Concern	Parent/Pt Concern			
Present at Exam	Dentist Concern _				
	Dentition				
R		- L			
Findings	Reco	mmendations			
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