Office Use Only:
A B C SS

GOBEILLE ORTHODONTICS

Confidential Responsible Party Information

Name

Marital Status:

Last

First Middle

Residence

Street

City State Zip

Mailing Address

Street

City State Zip

How long at address ______ Home # __ Work #

__ Cell #

Previous Address (if less than 3 years)

Street

City State

Relationship to Patient ____________________ Social Security # ______-_____-_______ Birthdate

/ /

Employer ______________________________ Occupation

_ # Years Employed

Spouse's Name

Relationship to Patient

Last

First Middle

Employer ______________________________ Occupation

Years Employed Social Security # ________-_______-

Birthdate / /

Home # Work #

Cell #

Email Address: ____

Confidential Responsible Party Information

CONFIDENTIAL" PATIENT" INFORMATION

Patient's Name

Last

First Middle

Address

Street

City State Zip

Home Phone Birthdate

/ / Social Security # - -

If minor, parent/guardian's name

Dentist

Whom may we thank for referring you to our office?

Insurance Information

Subscriber Name

Birthdate

/ /

Social Security # ___-___-___

ID # ____________ Group #

Insurance Co.

Phone

Do you have dual coverage? ☐Yes ☐No

If yes:

Subscriber Name

Birthdate

/ /

Social Security # ___-___-___

ID # ____________ Group #

Insurance Co.

Phone

Emergency Information

Name of nearest relative not living with you

Address

Home Phone Relationship

I understand that where appropriate, credit bureau reports may be obtained. I hereby authorize assignment of insurance benefits to Gobeille Orthodontics.

Signature (Parent or guardian if minor)

Date

Updates (date & initial)