Patient and Responsible Party Information

PATIENT INFORMATION:	**FAMILY INFORMATION: (If the patient is under 18)** Guardian/ Mother:	Guardian/Spouse/ Father:
Name: _____		
DOB _____/_____/_____	DOB _____ /_____/_____	DOB_____/_____/_____
Marital Status_____	Marital Status_____	Marital Status_____
S.S. #_____	S.S. #_____	S.S. # _____
Email: _____	Email: _____	Email: _____
Address _____	Address_____	Address _____
City _____	City_____	City _____
State_____ Zip _____	State _____Zip_____	State _____Zip_____
Home #_____	Home #_____	Home #_____
School/Employer: _____	Employer: _____	Employer: _____
School / Work # _____	Work #_____	Work # _____
Cell# _____	Cell#_____	Cell # _____
Insurance Co. _____	Insurance Co._____	Insurance Co._____

Nearest relative _____ Their # _____

*I hereby authorize release of any information to/ from insurance agencies listed above. I authorize payments directly to Dr. Nicholas S. Ising otherwise payable to me. **I understand that I am responsible for the total cost of orthodontic treatment if insurance benefits change during the course of treatment.

_____ _____

Signature (responsible party) **Date**

DO NOT SIGN OFFICE USE ONLY:

***I have reviewed all the above information and nothing has changed since my last appointment.**

_____ _____

Signature (responsible party) **Date**

***I have reviewed all the above information and nothing has changed since my last appointment.**

_____ _____

Signature (responsible party) **Date**