

# Welcome to Lustig Orthodontics

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## Patient Information

Patient Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_-\_\_\_\_-\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_-\_\_\_\_-\_\_\_\_ Patient Age \_\_\_\_yr. \_\_\_\_mo.  
How did you hear about our office? \_\_\_\_\_ Patient's Dentist \_\_\_\_\_

## Responsible Party Information

**Responsible Party's Name** \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Ph. \_\_\_\_-\_\_\_\_-\_\_\_\_ Cell Ph. \_\_\_\_-\_\_\_\_-\_\_\_\_ Work Ph. \_\_\_\_-\_\_\_\_-\_\_\_\_  
Email \_\_\_\_\_ Previous Address?(if less than 3 yrs.) \_\_\_\_\_  
SS# \_\_\_\_-\_\_\_\_-\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Drivers License # \_\_\_\_\_  
Employer \_\_\_\_\_ No. of years \_\_\_\_\_  
Employer Address \_\_\_\_\_ Occupation \_\_\_\_\_

**Father/Guardian Name** \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Ph. \_\_\_\_-\_\_\_\_-\_\_\_\_ Work Ph. \_\_\_\_-\_\_\_\_-\_\_\_\_ SS# \_\_\_\_-\_\_\_\_-\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Employer \_\_\_\_\_ No. yrs \_\_\_\_\_  
Employer Address \_\_\_\_\_ Occupation \_\_\_\_\_

**Mother/Guardian Name** \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Ph. \_\_\_\_-\_\_\_\_-\_\_\_\_ Work Ph. \_\_\_\_-\_\_\_\_-\_\_\_\_ SS# \_\_\_\_-\_\_\_\_-\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Employer \_\_\_\_\_ No. yrs \_\_\_\_\_  
Employer Address \_\_\_\_\_ Occupation \_\_\_\_\_

## Insurance Information

Insured's Name \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's SS # \_\_\_\_-\_\_\_\_-\_\_\_\_  
Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_  
Insurance Company Phone # \_\_\_\_-\_\_\_\_-\_\_\_\_ Insured's Employer \_\_\_\_\_  
Secondary Insured's Name \_\_\_\_\_ Insured's SS # \_\_\_\_-\_\_\_\_-\_\_\_\_  
Secondary Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_ Group \_\_\_\_\_  
Secondary Insurance Company Address \_\_\_\_\_  
Secondary Insurance Company Phone # \_\_\_\_-\_\_\_\_-\_\_\_\_ Secondary Insured's Employer \_\_\_\_\_

## Emergency Information

Emergency Contact (other than guardian) \_\_\_\_\_  
Relationship \_\_\_\_\_ Daytime Ph. \_\_\_\_-\_\_\_\_-\_\_\_\_ Alternative Ph. \_\_\_\_-\_\_\_\_-\_\_\_\_

I certify that all of the above information is true and it is my responsibility to inform this office of any changes, and that in order to receive complete information on financial options it is necessary for me to authorize a credit report.

**Signature** (Guardian's signature if a minor) \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Relationship to the patient \_\_\_\_\_ A B C F N