

Child Orthodontic Acquaintance Form

Patient's Information

Male Female First Name _____ Last Name _____

Prefer to be called _____ Birth Date ____ / ____ / ____ Grade _____

Is your child covered by orthodontic insurance? No Yes Child's E-mail _____

Special interests (sports or hobbies) _____

Siblings names and their birth dates: _____

How did you first hear about our office? _____

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

Contact Information

PERSON ACCOMPANYING CHILD **Mother** **Father** **Other** _____

First name _____ Last name _____ SS# _____ - _____ - _____

Occupation _____ Employer _____ How long _____

Marital Status: Married Single Divorced Separated Widowed Work phone (_____) _____

Child resides with Mother & Father Mother Father Other _____ Home phone (_____) _____

Current Address _____ Apt # _____ Cell phone (_____) _____

City _____ State _____ Zip _____ E-mail _____

Former Address (*if at current less than 3 years*) _____ Apt # _____

City _____ State _____ Zip _____

SECONDARY CONTACT **Mother** **Father** **Other** _____

First name _____ Last name _____ SS# _____ - _____ - _____

Occupation _____ Employer _____ How long _____

Marital Status: Married Single Divorced Separated Widowed Work phone (_____) _____

E-mail _____ Cell phone (_____) _____

(*if other than information above*) Home address _____ Apt # _____

City _____ State _____ Zip _____ Home phone (_____) _____

- I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence
- I understand that where appropriate, credit bureau reports may be obtained.
- I authorize the dental staff to perform the necessary orthodontic services my child may need for the initial consultation.
- I authorize that photos taken during treatment may be used in journal articles, promotional materials, our website/facebook pages, and are the property of Dr. Shaw and Dr. Ginzler.
- I authorize release of any information relating to any Insurance claim.
- I authorize payment directly, where applicable, to the office of Dr. Ginzler and Dr. Shaw.

Signature of parent or guardian _____ Date _____