Patient Name:

Patient Information Sheet

First Appointment: at at our office: Date:

Nickname: Patient ID:

Patient Address: Telephone:

Date of Birth: Age: Sex:

School/Employer: ______________ Grade/Position: ______________

Emergency Contact (Other than Parent/Guardian)
Name: ______________
Relationship: ______________
Phone: ______________

Best contact person to call (during business hours)
Name: ______________
Phone: ______________

Primary

☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify)

Marital Status: ______________

Responsible Party:

Date of Birth: ______________ SSN: ______________

Home Telephone:

Address:

Email Address: ______________

How Long? ______________

Employer: ______________ Position: ______________

Work Telephone: ______________

Cell Telephone: ______________

Name of Dental Carrier: ______________ Telephone: ______________

Dental Carrier Address: ______________

Subscriber ID: ______________ Group ID: ______________

Orthodontic Benefits: ______________

Secondary

☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify)

Marital Status: ______________

Responsible Party:

Date of Birth: ______________ SSN: ______________

Home Telephone: ______________

Address: ______________

How Long? ______________

Employer: ______________ Position: ______________

Work Telephone: ______________

Cell Telephone: ______________

Name of Dental Carrier: ______________ Telephone: ______________

Dental Carrier Address:

Subscriber ID: ______________ Group ID: ______________

Orthodontic Benefits: ______________

How Did You Hear About Us? ☐ Dentist ☐ Patient ☐ Relative ☐ Acquaintance ☐ Other

Whom May We Thank for Referring You?

Reason for Consultation:
Has an orthodontist been consulted previously? ______________
Have you had previous orthodontic treatment? ______________

Present Dentist:
Last Dental Visit: ______________

Names and Ages of Brothers & Sisters: ______________

Consent for Treatment

I, the undersigned, give my permission for treatment from Dr. John Monacell and his staff. I hereby authorize the taking of x-rays and other diagnostic records for an initial diagnosis if needed. I further acknowledge that the original diagnostic records are by State law, the property of the practice. I also give my approval and consent for the patient's name, photographs, and other diagnostic materials to be used in scientific, educational, and/or promotional work produced by Dr. Monacell and staff. I hereby authorize payment of insurance benefits directly to John F. Monacell, D.D.S., P.C., for services rendered to the patient. I also authorize the release of all patient records or other information necessary to determine benefits payable and/or which may be used for claims data analysis. I authorize the use and disclosure of protected health information to carry out treatment, payment activity, and Healthcare operations. I authorize you to send me information by electronic mail to include appointment reminders, account information, newsletters, and other practice promotional materials.

Signature: ______________ Relationship To Patient: ______________ Date: ______________