



PATIENT INFORMATION FORM

Today's Date: _____
Patient's Name: _____ DOB: _____ Age: _____
Preferred name: _____ Gender Assigned at Birth: _____
If you are a student, what school do you attend? _____ Grade: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Any other family members seen by our office? _____

Who referred you to our office? _____
Who is your general dentist (name and office phone#): _____

Emergency Contact #1 Name/Phone Number: _____ Relationship: _____
Emergency Contact #2 Name/Phone Number (if any): _____ Relationship: _____

Responsible Party Information (if your responsible party is yourself, please fill out first section only)

Parent/Responsible Party/Self#1

Name: _____ Best Contact ph#: _____
May we leave a detailed message? _____
Employer: _____ DL#: _____
SSN: _____ DOB: _____
Marital Status: Single Married Divorced

Parent/Responsible Party #2 (if applicable)

Name: _____ Best Contact ph#: _____
May we leave a detailed message? _____
Employer: _____ DL#: _____
SSN: _____ DOB: _____
Marital Status: Single Married Divorced

Primary Dental Insurance Information

Primary insured's name: _____ DOB: _____ SSN: _____
Relationship to patient: _____
Name of employer: _____
Insurance Company Name: _____
Member ID: _____
Group/Policy Number: _____
Insurance company customer service phone#: _____
Does your insurance have orthodontic coverage? Yes No

Secondary Dental Insurance (if applicable)

Primary insured's name: _____ DOB: _____ SSN: _____
Relationship to patient: _____
Name of employer: _____
Insurance Company Name: _____
Member ID: _____
Group/Policy Number: _____
Insurance company customer service phone#: _____
Does your insurance have orthodontic coverage? Yes No

(continued on back)

SIGNATURES AND AGREEMENTS

- I understand that to provide financing, a current form of ID is required.
- I understand that the parent/guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.
- If I agree to move forward with treatment with Suter Orthodontics, I authorize Suter Orthodontics to bill my insurance company on my behalf (if applicable).
- **I consent to receive appointment verifications via text message(Please circle):** **YES** **NO**

Printed name: _____ Signature: _____ Date: _____

Acknowledgement of Receipt of Suter Orthodontics HIPAA Notice of Privacy Practices

you may refuse to sign the below acknowledgement

I would like a printed copy of the office’s HIPAA notice. YES NO

This acknowledgement applies to:

Print Name: _____ Signature: _____ Date: _____

Child’s Name: _____ Child’s Name: _____

Child’s Name: _____ Child’s Name: _____

Child’s Name: _____ Child’s Name: _____

Suter Orthodontics may contact me regarding appointments, insurance questions, or account information on the following numbers:

Cell#: _____ Home#: _____

Email: _____ Email: _____

Please list any others with whom we may discuss account or treatment with:

Name: _____ Relationship: _____ Ph#: _____

Name: _____ Relationship: _____ Ph#: _____

Name: _____ Relationship: _____ Ph#: _____

-----OFFICE USE ONLY-----

We attempted to obtain written acknowledgment of receipt of our notice of Privacy Practices, but acknowledgment could not be obtained because:

Individual refused to sign _____ An emergency situation prevented us from obtaining acknowledgement _____

Other (please specify): _____

Office Employee Signature: _____