

**RAY MAXWELL, D.D.S., P. S.
ORTHODONTICS**

PATIENT INFORMATION (MINOR)

(PLEASE PRINT LEGIBLY)			TODAY'S DATE
PATIENT'S NAME (LAST, FIRST, INITIAL)	PREFERRED FIRST NAME	BIRTHDATE	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
STREET ADDRESS	CITY	ZIP	PHONE NO.
PATIENT LIVES WITH <input type="checkbox"/> MOTHER <input type="checkbox"/> OTHER (DESCRIBE) <input type="checkbox"/> BOTH PARENTS <input type="checkbox"/> FATHER		SCHOOL PATIENT ATTENDS	GRADE
PARENTS' MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> REMARRIED <input type="checkbox"/> SINGLE			
IN CASE OF EMERGENCY, NOTIFY (NAME)		PHONE	RELATIONSHIP TO PATIENT
HOW DID YOU FIND OUT ABOUT OUR OFFICE?		DENTIST'S NAME	
<input type="checkbox"/> DENTIST <input type="checkbox"/> TELEPHONE AD <input type="checkbox"/> FAMILY <input type="checkbox"/> FRIEND <input type="checkbox"/> OUTDOOR SIGN <input type="checkbox"/> OTHER (PLEASE DESCRIBE)			

- PLEASE COMPLETE THE SECTION BELOW.
- THE SECTION AT RIGHT IS REQUIRED FOR A SPOUSE OR OTHER PERSON WHO IS ALSO FINANCIALLY RESPONSIBLE FOR THE PATIENT'S ACCOUNT.

- FINANCIALLY RESPONSIBLE PERSON(S) WILL BE ASKED TO SIGN THE FINANCIAL AGREEMENT BEFORE TREATMENT BEGINS.
- I UNDERSTAND THAT WHERE NECESSARY, CREDIT BUREAU REPORTS MAY BE OBTAINED.

RESPONSIBLE PARTY, CUSTODIAL PARENT, OR LEGAL GUARDIAN	
NAME (LAST, FIRST, INITIAL)	
STREET ADDRESS (IF DIFFERENT THAN PATIENT'S)	
CITY	STATE ZIP
HOME PHONE NO.	WORK PHONE NO.
EMAIL ADDRESS FOR ACCOUNT ACCESS	
PATIENT RELATION TO THIS PERSON (SON, DAUGHTER, ETC.)	
EMPLOYER NAME	HOW LONG?
POSITION	UNION / LOCAL NO.
BIRTHDATE OF RESPONSIBLE PARTY	SOCIAL SECURITY NO.
DENTAL INSURANCE INFORMATION	
INSURANCE CO. NAME	GROUP NO.
INSURANCE CO. STREET ADDRESS	
CITY	STATE ZIP
INSUR. CO. PHONE NO.	
SUBSCRIBER'S FULL NAME	

OTHER FINANCIALLY RESPONSIBLE PERSON	
NAME (LAST, FIRST, INITIAL)	
STREET ADDRESS (IF DIFFERENT THAN PATIENT'S)	
CITY	STATE ZIP
HOME PHONE NO.	WORK PHONE NO.
EMAIL ADDRESS FOR ACCOUNT ACCESS	
PATIENT RELATION TO THIS PERSON (SON, DAUGHTER, ETC.)	
EMPLOYER NAME	HOW LONG?
POSITION	UNION / LOCAL NO.
BIRTHDATE OF RESPONSIBLE PARTY	SOCIAL SECURITY NO.
DENTAL INSURANCE INFORMATION	
INSURANCE CO. NAME	GROUP NO.
INSURANCE CO. STREET ADDRESS	
CITY	STATE ZIP
INSUR. CO. PHONE NO.	
SUBSCRIBER'S FULL NAME	

SIGNATURE OF PERSON COMPLETING FORM	DATE	RELATIONSHIP TO PATIENT
X		