PFLUGERVILLE
ORTHODONTICS

Patient Information

Patient Name: ______________________

Nickname: ______________________ Date of Birth: ______________________

Social Security Number: ______________________ Gender: ______________________

Address: ______________________ Home Phone: ______________________

City, State, Zip code: ______________________ Work Phone: ______________________

Email address: ______________________ Mobile Phone: ______________________

How would you like us to confirm future appointments? Choose one or both and enter information:

☐ Email: ______________________ ☐ Text: ______________________

General Information

Who can we thank for your referral? ______________________

What don't you like about your smile? ______________________

What are the patient's hobbies/interests? ______________________

Dentist/Physician information

Dentist Name: ______________________ Dentist Phone: ______________________

Last cleaning date: ______________________

Physician Name: ______________________ Physician Phone: ______________________

Is the patient currently under the care of a physician? ☐ Yes ☐ No

If yes, please explain ______________________

Parent Information (If patient is a minor) and Insurance Information

Father's Name: ______________________ Social Security number: ______________________

Address ______________________ Date of Birth: ______________________

City, State, Zip code: ______________________ Home phone: ______________________

Email address: ______________________ Work phone: ______________________

Employer: ______________________ Mobile phone: ______________________

Insurance company: ______________________ Insurance phone number: ______________________

Insurance address: ______________________ Insurance group number: ______________________

Insurance city, state, zip: ______________________ Insurance ID number: ______________________

Spouse's Name: ______________________

Mother's Name: ______________________ Social Security number: ______________________

Address: ______________________ Date of Birth: ______________________

City, State, Zip code: ______________________ Home phone: ______________________

Email address: ______________________ Work phone: ______________________

Employer: ______________________ Mobile phone: ______________________

Insurance company: ______________________ Insurance phone number: ______________________

Insurance address: ______________________ Insurance group number: ______________________

Insurance city, state, zip: ______________________ Insurance ID number: ______________________

Spouse's Name: ______________________

Siblings' Names and Ages:

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Parent/Guardian name: ______________________ Date: ______________________

Signature: ______________________

Relationship to patient: ______________________