

**ORTHODONTIC ACQUAINTANCE CARD**

Appt Date/Time \_\_\_\_\_

Computer Number \_\_\_\_\_ Date \_\_\_\_\_

Family Number \_\_\_\_\_ Pano \_\_\_\_\_

**PLEASE PRINT**

**PATIENT INFORMATION**

Patient's Name \_\_\_\_\_  
Last First Middle Nickname

Address \_\_\_\_\_  
Street City State Zip Code

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_  
Area Code

Social Security No. \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Hobbies \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

Name \_\_\_\_\_  
Mr. Dr. Last First Middle Marital Status  
Mrs. Ms.

Address \_\_\_\_\_  
Street City State Zip Code

How long at this address? \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_  
Area Code Area Code

Previous Address (if less than 3 yrs.) \_\_\_\_\_  
Street City State Zip Code

Social Security No. \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_ No. of years employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. of years employed \_\_\_\_\_

Spouse's Social Security No. \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_  
Area Code

**INSURANCE INFORMATION**

Insured's Name \_\_\_\_\_ Insured's Social Security No. \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_ Insured's D.O.B. \_\_\_\_\_

Insurance Company Address \_\_\_\_\_  
Street City State Zip Code

Insurance Company Telephone (\_\_\_\_\_) \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_  
Street City State Zip Phone (\_\_\_\_\_) \_\_\_\_\_  
Area Code

**EMERGENCY INFORMATION**

Name of nearest friend or relative not living with you \_\_\_\_\_

Complete Address \_\_\_\_\_  
Street City State Zip Code (\_\_\_\_\_) Phone \_\_\_\_\_

**GENERAL INFORMATION**

Friends or relatives treated here \_\_\_\_\_

Names and ages of other children in family \_\_\_\_\_

Patient's Dentist \_\_\_\_\_ City \_\_\_\_\_

Dental examination within last six months? \_\_\_\_\_ If yes, date of last visit \_\_\_\_\_

Reasons for seeking orthodontic treatment \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

I hereby authorize the release of any information relating to this claim. I hereby also authorize payment of the insurance benefits directly to Dr. C. Dwayne Trammell.

X \_\_\_\_\_