Booth Orthodontics

Date _____ **Confidential Responsible Party Information** A B C

Name _____ Marital Status _____
(Father or Self) Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Yrs Employed _____

Mother's Name _____ Relationship to Patient _____
(or Spouse) Last First Middle

Residence _____ Home Phone _____

Employer _____ Occupation _____ No. Yrs Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Confidential Patient Information

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

Dentist Name and Office Address _____

Whom may we thank for referring you to our office _____

Emergency Information

Name of nearest relative not living with you _____ Relationship _____

Address _____ Phone _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (date & initial) _____ E-MAIL ADDRESS: _____

CONFIDENTIAL (for record and pretreatment evaluation)