Wavescape Orthodontics: Patient Information Form

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev. ☐ Other: _____

Patient Name: _____
First Last (Name Called)

Birthday: _____

Home Phone: _____ Mobile Phone: _____

Address: _____

Address: _____

Post Code: _____

Sex M ☐ F ☐ U ☐ EMail: _____

Dentist: _____

Physician _____

Who referred you to our practice? _____

Any Medical Problems? _____

Responsible Party Information

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev. ☐ Other: _____

Responsible Party Name: _____
First Last (Name Called)

Birthday: _____

Home Phone: _____ Work Phone: _____

Address: _____

Address: _____

Post Code: _____

Sex M ☐ F ☐ U ☐ Relationship to Patient: _____

Is this Responsible Party Financially Responsible for Charges? yes ☐ no ☐

Is this the Primary Person who brings patient to appointments? yes ☐ no ☐

Insurance Company: _____

Group Number: _____ Phone: _____

Address: _____

Employer: _____

Address: _____

Additional Information

List Family Members that are currently in our practice: _____

_____

_____

How did you hear about Wavescape? _____

_____

_____