

Welcome to Dr. Alexander's Office!
Patient Information Form

Patient Name: _____
Last First Middle Initial

Date of Birth _____ Age _____ Male _____ Female _____

Street Address _____ Phone # _____

City _____ State _____ Zip _____

E-Mail Address _____

Occupation _____ Work Phone _____

Employer _____ Patient SS# _____

Spouses' Name _____
Last First Middle Initial

Date of Birth _____ SS# _____ Occupation _____

Work Phone _____ Employer _____

Names and ages of children in the family (if applicable)

Who may we thank for referring you to our office? _____

Dentist's Name _____ Office phone _____

Physician's Name _____ Office phone _____

Have you been seen by another orthodontist? Yes _____ No _____

If so, Doctor's name _____

Person financially responsible _____ SS# _____

Address _____

Do you have insurance that will cover orthodontics? Yes _____ No _____ If so, please list below:

Subscriber # 1 _____ Subscriber #2 _____

Company Name _____ Company Name _____

Group # _____ Group # _____

Policy # (SS#) _____ Policy # (SS#) _____

Reason for exam: _____

Patient's Hobbies/Interests _____

Signature _____ Date _____