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 ____________

School ____________________________________ Grade ____________

Patient lives with ____________________________________ Patient SS# ____________

Father's Name ____
Last First Middle Initial

Date of Birth ____________________ SS# ____________________ Occupation ____________________

Work Phone ____________________ Employer ____________________________________

Mother's 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 ____________________

Has patient been seen by another orthodontist? Yes ____________ No ____________

If so, Doctor's name ____________________________________

Person financially responsible ____________________________________ SS# ____________________

Address ____________________________________ E-Mail 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: ____________________