

**Dr Paul Yurfest**  
**Diplomate American Board of Orthodontics**  
**Standard and Lingual Braces**

**New Patient Information**

***Patient***

Name-Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  
Sex M F Age \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Parent\Guardian's Name \_\_\_\_\_

***Responsible Party Information***

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Marital Status \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Mailing Address (if Different) \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_  
Relation to Patient \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_

***Dental Insurance Information***

Insured's Name \_\_\_\_\_ Insured's SS# \_\_\_\_\_  
Insured's Birthdate \_\_\_\_\_  
Employer \_\_\_\_\_ Employer Address \_\_\_\_\_  
Insurance Co. \_\_\_\_\_ Group# \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_  
Insurance Phone # \_\_\_\_\_

***Emergency Information***

Name of the nearest relative not living with you \_\_\_\_\_  
Complete Address \_\_\_\_\_  
Phone# \_\_\_\_\_

I certify that the above information is accurate, and I agree to inform this office if any of the following information changes.

**Patient/Guardian Signature** \_\_\_\_\_

**Who is your Family Dentist?** \_\_\_\_\_

**Dentist Address & Phone Number:** \_\_\_\_\_

**Who referred you to our office?** \_\_\_\_\_