WEST PACES FERRY ORTHODONTICS
Dr. Paul Yurfest/Dr. Kristin L. Huber
Diplomate America Board of Orthodontics
Standard and Invisalign Braces
www.westpacesferryortho.com

NEW PATIENT INFORMATION

PATIENT

NAME LAST_____FIRST_____MI_____
SEX M F AGE_____ BIRTHDATE_____ SOCIAL SECURITY #_____
ADDRESS_____
CITY_____ STATE_____ ZIP_____
EMAIL _____
HOME PHONE_____ WORK PHONE _____
CELL PHONE _____EMPLOYER NAME _____
PARENT/GUARDIAN NAME_____

RESPONSIBLE PARTY INFORMATION

NAME LAST_____FIRST_____ MARITAL STATUS_____
ADDRESS_____ CITY_____ STATE_____ZIP_____
MAILING ADDRESS (IF DIFFERENT) _____
HOME PHONE_____WORK PHONE_____EMAIL_____
SOCIAL SECURITY #_____ BIRTHDATE_____
RELATION TO PATIENT_____ OCCUPATION_____

EMERGENCY INFORMATION

NAME OF THE NEAREST REALTIVE NOT LIVING WITH YOU _____
COMPLETE ADDRESS_____
PHONE_____

DENTAL INSURANCE INFORMATION

INSURED'S NAME_____ INSURED'S SOCIAL SECURITY # _____
INSURED'S BIRTHDATE_____ INSURED'S EMPLOYER NAME_____
EMPLOYER ADDRESS_____
INSURANCE CO. NAME_____ GROUP #_____ PLAN TYPE_____
INSURANCE CO. ADDRESS_____ INSURANCE PHONE #_____

NAME OF FAMILY DENTIST_____
DENTAL ADDRESS_____
PHONE_____

WHO REFERRED YOU TO OUR OFFICE? _____

I CERTIFY THAT THE ABOVE INFORMATON IS ACCURATE, AND I AGREE TO INFORM THIS OFFICE OF ANY INFORMATION CHANGES.

PATIENT/GUARDIAN SIGNATURE

_____

DATE