KEITH W. KOCH, D.D.S., P.C.

ORTHODONTICS FOR CHILDREN AND ADULTS

Today's Date_____

Appointment Date_____

PATIENT INFORMATION

C.R. _____

Patient's Name _____
Last Name First Name Middle Name / Initial

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Age _____ Social Security # _____

Work Phone _____ If patient is a minor, give parent's or guardian's name _____

Cell Phone # _____ E-mail _____

Whom may we thank for referring you to our office? _____ Patient's Dentist _____

RESPONSIBLE PARTY INFORMATION

Who is financially responsible for this account?

Name_____ _____
Last Name First Name Middle Name / Initial Marital Status

Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Cell Phone _____ E-mail _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Birthday _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Secondary Name_____ Relationship to Patient _____
Last Name First Name

Secondary Employer _____ Secondary Occupation _____ No. Years Employed _____

Secondary Social Security # _____ Secondary DOB _____ Secondary Work Phone _____

Secondary Cell Phone_____ Secondary E-mail _____

Are the Parents married? ___Yes ___No Separated? ___Yes ___No Divorced? ___Yes ___No Remarried? ___Yes ___No

Other adults we should know about?

1) _____
Last Name First Name Relationship to Patient

_____ _____ _____
Home Phone Work Phone Cell Phone

2) _____
Last Name First Name Relationship to Patient

_____ _____ _____
Home Phone Work Phone Cell Phone

DENTAL INSURANCE INFORMATION

Primary Insured's Name _____ Insurance I.D. Number _____

Insured's Address_____ Insured's Phone _____ Insured's DOB _____

Insurance Co. Name and Address _____ Phone No. _____

Insured's Employer _____

Do you have dual dental coverage? Yes ____ No ____ If Yes:

Secondary Insured's Name _____ Insurance I.D. Number _____

Secondary's Address _____ Secondary's Phone _____ Secondary's DOB _____

Insurance Co. Name and Address _____ Phone No. _____

Secondary Employer _____

I understand that where appropriate, credit bureau reports may be obtained:

Signature _____

Updates (date & initial) _____

*** PLEASE COMPLETE OTHER SIDE ***

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

Patient's Date of Birth _____

Patient's Dentist _____ City _____

Date of Patient's Last Dental Visit _____

Cleaning _____

What is patient's primary concern about his/her teeth? _____

_____

Has Patient ever had any previous orthodontic treatment? _____

_____

Siblings or children and their dates of birth _____

_____

_____

_____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address _____

Home Phone _____ Work Phone _____ Cell Phone _____