KEITH W. KOCH, D.D.S., P.C.
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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 _____ Cell Phone # _____ Birth date _____

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

E-mail _____

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

Patient's Dentist _____ Date of Last Cleaning_____

RESPONSIBLE PARTY INFORMATION

Who is financially responsible for this account? (Parent / Guardian / Self)

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 _____

Social Security # _____ Birthday _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Secondary Name_____ (Last Name) (First Name) Relationship to Patient _____

Secondary Employer _____ Secondary Occupation _____ No. Years Employed _____

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

Secondary Cell Phone_____ Secondary E-mail _____

Signature of Responsible Party_____

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

Other adults authorized to discuss: ☐ Treatment ☐ Financials

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

☐ No Insurance

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 _____

*** PLEASE COMPLETE OTHER SIDE ***

EMERGENCY INFORMATION

NAME_____

Address _____
Street City State Zip

Cell Phone_____

CREDIT

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

Printed Name_____

Signature_____

Date_____