DATA SHEET - MINOR (under 18)

Orthodontic Associates of New England

PATIENT INFORMATION:

Patient's Name _____ Nickname _____

Address _____ Male/Female _____

_____ Home Phone (___) _____

Date of Birth _____ Age _____ Cell Phone (___) _____

RESPONSIBLE PARTIES:

Father's Name _____ Mother's Name _____

Address _____ Address _____

_____ _____

Occupation _____ Occupation _____

Daytime Phone (____) _____ Daytime Phone (____) _____

PRIMARY ORTHODONTIC INSURANCE:

Insured's Name _____

Relation to Patient _____

Insured's Birth Date _____

Insured's Social Security No. _____

Insured's Employer _____

Insurance Company _____

Insurance Co. Phone No. (____) _____

SECONDARY ORTHODONTIC INSURANCE:

Insured's Name _____

Relation to Patient _____

Insured's Birth Date _____

Insured's Social Security No. _____

Insured's Employer _____

Insurance Company _____

Insurance Co. Phone No. (____) _____

DENTAL HISTORY:

Family Dentist _____ City _____

Date of Last Cleaning _____

Previous Dental Problems _____

Have any teeth been injured, loosened or knocked out? _____

Describe in your own words your main orthodontic concern: _____

_____

Who recommended you to our office? _____

Any family members in treatment with us? _____

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Orthodontic Associates of New England/James R. Metcalf, D.M.D., P.C. to release any information, including the diagnosis and the records of any treatment rendered my child, to Third Party Payers and/or Health Practicioners.

Signed _____ Date _____

Relationship to Patient _____