Patient's Last Name: ______________________________ First Name: _________________________ Middle Name: __________________

Birth Date: ______________________ Age: ______ Sex: Male Female I prefer to be called: ______________________________

S.S.N: _______________________________ Email: ____

Home Phone: _________________________ Cell Phone: __________________________ Work Phone: ______________________________

Patient's Address: ____

City: ____ State: ____________________________ Zip Code: __________________

Occupation: ___________________________ Employer: _______________________________________ Years with Employer: __________

Patient is: Single □ Married □ Widowed □ Separated □ Divorced □

Name of Spouse/Closest Relative: ___________________________________ Phone Number: _____________________________________

Relationship To you: ____

Address (if different than yours): ____

City: ____ State: ____________________________ Zip Code: __________________

Name of Patient's Dentist: ____ Phone No: _________________________________

Dentist's Address: ____

City: ____ State: ______________________________ Zip Code: ___________________

Date Last Seen: _____________________ Reason: ____

Name of Patient's Physician: ____ Phone No: _________________________________

Physician's Address: ____

City: ____ State: ______________________________ Zip Code: ___________________

Date Last Seen: _____________________ Reason: ____

Who suggested that you might need orthodontic treatment? ____

How were you referred to our office? ____

Who is Financially Responsible For This Account?

Last Name: ___________________________First Name: ________________________ Middle Name/Initial: ________________

Address (if different than the patient's): ____

City: ____ State: __________________________ Zip Code: _________________

Insurance Coverage for Dental Treatment? Yes No

Insurance Coverage for Orthodontic Treatment? Yes No

Primary Policy Holder's Name: ____ S.S.N.: __________________________

Birth Date: __________________________ Employed By: ____

Dental Insurance Company: ____ Group No.: __________________________

Medical Insurance Company: ____ Group No.: __________________________

Secondary Policy Holder's Name: ____ S.S.N.: __________________________

Birth Date: __________________________ Employed By: ____

Dental Insurance Company: ____ Group No.: __________________________

Medical Insurance Company: ____ Group No.: __________________________

Release of Information

I authorize Lockett Orthodontics to release any information including the diagnosis and the records of treatment or examination rendered during the period of such care to third party payers and or other health practitioners. I authorize and request my insurance company to assign benefits and pay directly to Lockett Orthodontics those benefits that would otherwise be payable to me. I understand that my insurance carrier may pay less than the actual bill for these services. I authorize the use of my signature on all insurance submissions. I agree to be responsible for payment of all services rendered on my behalf.

____ ____

Patient Signature Date

Consent for Orthodontic Records

I hereby consent to the making of diagnostic records (x-rays, photos, models) throughout treatment by Dr. Lockett and staff for the above individual. I fully understand all of the risks associated with these procedures.

____ ____

Patient Signature Date