THAI AND KIOURTSIS ORTHODONTICS

Please take a few minutes to thoroughly complete this form. Thank You.

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

## Patient Information

Name (Last, First, MI) _____

Mailing Address _____ City _____ State _____ Zip_____

How long at this address? _____ Previous Address (if less than 3 yrs.) _____

Home Phone _____ Cell Phone # _____ Carrier (AT&T, Verizon...) _____

Work Phone (If we may contact you there) _____ Email Address: _____

Preferred method of contact for appointments: Email _____ Text Message _____ Both _____

Date of Birth _____

Employer _____ Occupation _____Years Employed _____

Spouse's Name (Last, First, MI) _____

Employer _____ Occupation_____ Years Employed_____

## Emergency Information

Name **and** relationship of nearest emergency contact not living with you _____

Address _____Phone Number _____

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

Signature _____

## Dental Insurance Information

(If you do not have orthodontic coverage, there is no need to provide us with your dental insurance information, nor do we need your medical insurance information.)

Subscriber's Name _____ Subscriber's SSN _____ ID#_____

Subscriber's Employer _____Subscriber's Date of Birth _____

Insurance Company _____ Group Number _____

Insurance Company Address _____ Phone Number _____

*** I authorize payment directly to Kiourtsis Orthodontics of the group insurance benefits otherwise payable to me:**

Subscriber's Signature _____

**Do you have dual coverage? Yes _____ No _____**

**Authorization to Release Information (please initial) Yes_____ No_____**