LOCKETT ORTHODONTICS

Patient's Last Name: _____ First Name: _____ Middle Name: _____

Birth Date: _____ Age: _____ Sex: Male ☐ Female ☐ I prefer to be called: _____

S.S.N: _____ Home Phone: _____

Patient's Address: _____

City: _____ State: _____ Zip Code: _____

Attends School At: _____

Musical Instruments Played: _____

Sports and/or Hobbies: _____

Number of brothers and sisters: _____ Ages: _____

Other family members treated here: _____

Birth Father's Height ____ ft. ____ in. Birth Mother's Height ____ ft. ____ in.

Patient's Birth Weight ____ lbs. ____ oz. Patient's Present Weight ____ lbs. Height ____ ft. ____ in.

Custodial Parent(s) or Guardian(s): _____

Phone No (if different than the patient's): _____

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

City: _____ State: _____ Zip Code: _____

Email Address: _____ Cell No: _____

Name of Patient's Dentist: _____ Phone No: _____

Date Last Seen: _____ Reason: _____

Name of Patient's Physician: _____ Phone No: _____

Date Last Seen: _____ Reason: _____

Has Patient seen an Orthodontist in the last 9 months? ☐yes ☐no If yes, please answer the following questions:

When? _____ By Whom? _____

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: _____

If less than five years, previous address: _____

City: _____ State: _____ Zip Code: _____

Phone No. (if different than patient's): _____ S.S.N.: _____

Employer: _____ How many years? _____

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.: _____

Who suggested that your child might need orthodontic treatment? _____

How were you referred to our office? _____

Release of Information

I authorize Lockett Orthodontics to release any information including the diagnosis and the records of treatment or examination rendered to my child 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 or my dependents.

_____ _____

Signature of Custodial Parent or Guardian 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.

_____ _____

Signature of Custodial Parent or Guardian Date