



PINE TOP
ORTHODONTICS
russell h. ford, dmd, ms

Date: _____

PATIENT INFORMATION

Patient's Name: _____
Last First Middle

Address: _____
Street City State Zip Code

Home Phone: _____ Birthdate: _____ Age: _____

Who is your General Dentist?: _____

How did you hear about our office? _____

RESPONSIBLE PARTY INFORMATION

Name: _____
Last First Middle Marital Status

Relationship to Patient: _____

Address (if different from above): _____
Street City State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address: _____

Spouse: _____
Last First Middle

Relationship to Patient: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address: _____

How would you prefer to be contacted for appointment reminders (i.e., phone, text, e-mail)? _____

DENTAL INSURANCE INFORMATION

Insured's Name: _____ SS or ID #: _____ Birthdate: _____

Insurance Co.: _____ Group #: _____ Telephone #: _____

Insurance Co. Address: _____
Street City State Zip Code

Insured's Employer: _____

Do you have dual coverage? If yes:

Insured's Name: _____ SS or ID #: _____ Birthdate: _____

Insurance Co.: _____ Group #: _____ Telephone #: _____

Insurance Co. Address: _____
Street City State Zip Code

Insured's Employer: _____

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