



ORTHODONTIC ACQUAINTANCE SHEET

Patient Information

Chart #: _____

Name: _____ Birthdate: _____ Age: _____ Gender: _____
 Address: _____ City: _____ State: _____ Zip Code: _____
 Home Phone: (____) _____ Work Phone: (____) _____ Mobile: (____) _____
 Patient's Dentist: _____ Patient's Physician: _____
 Social Security #: _____ Driver's License #: _____ State: _____
 Employer: _____ Business Phone: (____) _____
 Business Address: _____ City: _____ State: _____ Zip: _____
 E-mail Address: _____

Responsible Party

Name: _____ Relationship to Patient: _____ Birthdate: _____
 Address: _____ City: _____ State: _____ Zip Code: _____
 Term of Tenancy at Current Address: _____ Home Phone: (____) _____ Mobile: (____) _____
 Social Security #: _____ Driver's License #: _____ State: _____
 Employer: _____ Business Phone: (____) _____
 Business Address: _____ City: _____ State: _____ Zip: _____
 Date of Hire: _____ Union/Local: _____ Group Number: _____
 Name of Insurance Co. _____ Insurance Phone: (____) _____
 Ins. Co. Mailing Address: _____ City: _____ State: _____ Zip: _____

Second Insurance Information (Complete this section if the patient is covered by a second insurance company)

Name: _____ Relationship to Patient: _____ Birthdate: _____
 Social Security #: _____ Driver's License #: _____ State: _____
 Employer: _____ Business Phone: (____) _____
 Business Address: _____ City: _____ State: _____ Zip: _____
 Date of Hire: _____ Union/Local: _____ Group Number: _____
 Name of Insurance Co. _____ Insurance Phone: (____) _____
 Ins. Co. Mailing Address: _____ City: _____ State: _____ Zip: _____

Getting to Know You and Your Family

How did you hear about Dr. Humphries? _____
 When were your last x-rays: _____ When was your last dental visit? _____
 What treatment was performed? _____ How often do you have your teeth cleaned? _____
 Please list the Names and ages of other children in the family: _____

I hereby authorize any insurance company, benefit trust fund, prepayment organization, employer, hospital, physician, or dentist to release information with respect to myself or any of my dependents which may have a bearing on benefits payable under this or any other plan providing benefits or services. I certify that the foregoing information is correct to the best of my knowledge and belief.

Signature of Insured: _____ Date: _____

I hereby authorize payment directly to Sage M. Humphries D.D.S., M.S., Inc. of the insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize dental care and release and information relating to this claim.

Signature of Insured: _____ Date: _____