Craig & Streight
ORTHODONTICS
Robi Lynn Craig, DDS
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Patient Information

Patient Name: _____
Birthdate: _____ Age: _____ Sex: ☐ M ☐ F E-Mail Address _____
Address: _____ City/State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
If patient is a minor, accompanying parent/guardian name: _____
Dentist: _____ Physician: _____
Other family members treated here: _____
Student: ☐ Full Time ☐ Part Time School Name: _____
Patient living with: ☐ Mother ☐ Father ☐ Both ☐ Other: _____
Employed: ☐ Full Time ☐ Part Time Employer: _____
Number of years employed: _____ Occupation: _____
Whom may we thank for referring you to our office? _____
Name of nearest relative not living with you _____ Phone _____
Address _____ City/State _____ Zip Code: _____

Primary Responsible Party Information

Name: _____ Relationship to patient: _____
Birthdate: _____ Email: _____
Marital Status: _____ Address: _____
City/State: _____ Zip Code: _____ How Long at this Address? _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Employer: _____ Occupation: _____ Number Years Employed: _____
Spouse's Name: _____ Relationship to Patient: _____
Birthdate: _____ Email: _____
Work Phone: _____ Cell Phone: _____
Spouse's Employer: _____ Occupation: _____ Number Years Employed: _____

Secondary Responsible Party Information

Name: _____ Relationship to patient: _____
Birthdate: _____ Email: _____
Marital Status: _____ Address: _____
City/State: _____ Zip Code: _____ How Long at this Address?: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Employer: _____ Occupation: _____ Number Years Employed: _____
Spouse's Name: _____ Relationship to Patient: _____
Birthdate: _____ Email: _____
Work Phone: _____ Cell Phone: _____
Spouse's Employer: _____ Occupation: _____ Number Years Employed: _____

Insurance Information

IS PATIENT COVERED BY ORTHODONIC INSURANCE? Yes_____ No_____
Name of Primary Insurance Company: _____ Phone #: _____
Address: _____
Insured's Name: _____ SSN or ID#: _____ Group #: _____
Insured's Birthdate: _____ Employer: _____ Insured's relation to patient: _____
Name of Secondary Insurance Company: _____ Phone #: _____
Address: _____
Insured's Name: _____ SSN or ID#: _____ Group #: _____
Insured's Birthdate: _____ Employer: _____ Insured's relation to patient: _____

I authorize relase of any information relating to this claim.
I understand that I am responsible for all costs of dental treatment.

_____

I hereby authorize payment directly to the Dentist of the group insurance benefits otherwise payable to me.

_____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes. I understand credit bureau reports will be obtained for financial arrangements.

_____ _____
Signature of parent or guardian Date