MIDWEST ORTHODONTICS

NEW PATIENT REGISTRATION FORM

Midwest Orthodontics
www.Midwestorthodontics.com

Referral Source: _____

Email: _____ Preferred to be contacted by: ☐ e-mail ☐ phone

☐ Yes! Please send me appointment reminders via email

Our forms are printed on paper sourced from sustainable forests. Soon we will become a paperless practice!
*Help support our **Green Initiative** by providing your email address to receive statements and reminders digitally.*

SECTION I: Patient Information

First Name _____ Last Name _____ Preferred Name_____

Home Address: _____City: _____ State: _____Zip Code:_____

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

Date of Birth: _____ Soc. Sec. #: _____

Marital Status: ☐ Minor ☐ Single ☐ Married/Partner ☐ Separated ☐ Divorced ☐ Widowed

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to specify

Race: ☐ African American ☐ Caucasian ☐ American Indian or Alaskan Native ☐ Asian Indian ☐ Other_____

Preferred Language: ☐ English ☐ Spanish ☐ Other, please specify _____

Employment Status: ☐ Employed ☐ Unemployed ☐ Student ☐ Retired ☐ Other/Not Applicable

Emergency Contact Name _____ Phone (_____)_____ Relationship _____

Section II: Responsible Party Information

(If someone other than patient, and/or patient is under age 18)

Relationship to Patient: ☐ Self ☐ Spouse/Partner ☐ Parent ☐ Other: _____

Name (Last, First): _____

Address (Line 1): _____City: _____State:_____ Zip Code: _____

Date of Birth: ____/____/_____ Soc. Sec. # : _____ StateID/License#:_____

Home Phone: (_____)_____ Cell Phone: (_____)_____ Work Phone: (_____)_____

Section III: Insurance Information

Name of Insured: _____ Insured's Soc. Sec. #: _____Insured's Date of Birth: _____

Employer: _____ Employer Address: _____

Insurance Provider: _____Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Additional Insurance: Name of Insured: _____ Insured's Soc. Sec. #: _____

Insured's Date of Birth: _____Employer: _____ Employer Address: _____

Insurance Provider: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Signature _____ Date: _____