BERNARDO CALDAS
ORTHODONTICS

# NEW PATIENT INFORMATION

## PATIENT INFORMATION

Patient full legal name

Preferred name

Date of birth

Street address / apartment

City

State

ZIP code

Gender (optional)

Mobile phone

Alternate phone (optional)

Email address

## PARENT / GUARDIAN - COMPLETE FOR A MINOR

Parent / guardian name(s)

Relationship to patient

Phone (or write "same as above")

Email (or write "same as above")

## EMERGENCY CONTACT

Contact name

Relationship

Phone

## GENERAL DENTIST & REFERRAL

General dentist name (write "none" if none)

Dental office

Dental office phone

Dental office city

How did you hear about us? Select all that apply.

- ☐ General dentist
- ☐ Friend / family
- ☐ Online search
- ☐ Social media
- ☐ Insurance
- ☐ Community event
- ☐ Other

Who referred you? Name / details (if any)

## DENTAL INSURANCE - IF APPLICABLE

Dental insurance carrier (write "none" if uninsured)

Subscriber full name

Subscriber relationship to patient

Subscriber date of birth

Member / subscriber ID

Group number

Subscriber employer

Please provide the front and back of your insurance card at your visit or through the practice's approved secure method.

Please complete the separate Medical History form for health, medications, allergies, sleep/airway and jaw/TMD questions.