Dr. Todd K. Rowe Orthodontist•PC

Patient's Name_____
Last First MI Birthdate

Address_____
Street City State Zip

Home Phone_____

If Patient is a minor, give parent's name or guardian's name_____

Confidential Responsible Party Information

A B C

Name_____ Marital Status_____
Last First Middle

Residence_____
Street City State Zip

Mailing Address_____
Street City State Zip

How long at this address_____ Home Phone_____ Work Phone_____

Previous Address (if less than 3 yrs.)_____
Street City State Zip

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ No. Years Employed_____

Spouse's Name_____ Relationship to Patient_____
Last First Middle

Employer_____ Occupation_____ No. Years Employed_____

Social Security #_____ Birthdate_____ Work Phone_____

Dental Insurance Information

Policy Holder's Name_____ Soc.Sec. #_____

Insurance Company_____ ID# _____ Grp# _____

Insurance Co. Address_____ Insurance Co. Phone_____

Policy Holder's Employer_____

Does the patient have dual coverage? No ☐ Yes ☐ If yes:

Policy Holder's Name_____ Soc. Sec. #_____

Insurance Company_____ ID# _____ Grp# _____

Insurance Co. Address_____ Insurance Co. Phone_____

Policy Holder's Employer_____

Emergency Information

Name of nearest relative not living with you_____

Complete Address_____

Phone_____ Relationship to patient:_____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor)_____ Date _____

Updates (date & initial)_____