



Dr. Michael Richards Orthodontics
Simply Spectacular Smiles

PATIENT INFORMATION

Patient's name _____ Age _____ Sex: F () M ()
Birth date ___/___/___ Social Security # _____ E-Mail _____
Home Address _____
City, State _____ Zip _____ How long at this address? _____
Home Phone _____ School _____ Grade _____
If patient is a minor, give custodial parent's name or guardian's name _____
Patient's hobbies _____
General Dentist _____ Dentist Phone _____
How did you hear about Smile for a Lifetime? _____

PARENT OR GUARDIAN INFORMATION

Name _____ Marital Status _____ E-Mail _____
Home Address _____ Own () Rent ()
City, State _____ Zip _____ How long at this address: _____
Home Phone _____ Work Phone _____ Cell Phone _____
Social Security # _____ Birth date ___/___/___ Relationship to patient _____
Employer _____ Occupation _____ Household income (per year) _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ Insurance ID # _____
Insured's Birth date ___/___/___ Relationship to patient _____
Insurance Company _____ Phone # _____
Employer _____ Group # _____
Do you have dual coverage? YES NO If yes, please complete the following section:
Insured's Name _____ Insurance ID # _____
Insured's Birth date ___/___/___ Relationship to patient _____
Insurance Company _____ Phone # _____
Employer _____ Group # _____

ADDITIONAL INFORMATION

Submitted by: _____ Relationship: _____ E-Mail _____
Home Address _____ City, _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____

