BLUE SKY ORTHODONTICS

NEW PATIENT FORM

1. PATIENT INFORMATION

Today's Date: ____/____/____ ☐ Male ☐ Female

Patient Name: _____
LAST FIRST MI

Nickname: _____

Date of Birth: ____/____/____ Age: _____

Home Address: _____

_____
CITY STATE ZIP

Home#: _____ Cell#: _____

Email: _____

School: _____ Grade: _____

Hobbies/Sports: _____

2. RESPONSIBLE PARTY

Name: _____
LAST FIRST MI

Relation to Patient: _____

Date of Birth: ____/____/____ DL#: _____

Billing Address: _____

_____
CITY STATE ZIP

Home#: _____ Cell#: _____

Email: _____

Employer: _____

Work#: _____

3. EMERGENCY CONTACT

Name: _____
LAST FIRST MI

Home#: _____ Cell#: _____

Relation to Patient: _____

4. PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage: ☐ Y ☐ N

Insurance Co. Name: _____

Insurance Phone#: _____

Group/ID#: _____

Policy Owner's Name: _____

SS#: _____ Date of Birth: ____/____/____

Relation to Patient: _____

Policy Owner's Employer: _____

FOR OFFICE USE ONLY

Effective Date:____/____/____ Pays: _____%

Lifetime Max: _____ Age Limit: _____

Pays: ☐ Auto ☐ Bill Driven | ☐ Monthly ☐ Quarterly

Benefits Used: _____

Coordinate Benefits: _____

4. SECONDARY ORTHODONTIC INSURANCE

Insurance Co. Name: _____

Insurance Phone#: _____

Group/ID#: _____

Policy Owner's Name: _____

SS#: _____ Date of Birth: ____/____/____

Relation to Patient: _____

Policy Owner's Employer: _____

FOR OFFICE USE ONLY

Effective Date:____/____/____ Pays: _____%

Lifetime Max: _____ Age Limit: _____

Pays: ☐ Auto ☐ Bill Driven | ☐ Monthly ☐ Quarterly

Benefits Used: _____

Coordinate Benefits: _____