JEDIDIAH R. GASS, DDS,MSD,PC

Patient Information

Date:

Patient's Name (last): (first): (middle):

Gender: ❑ male ❑ female School (if applicable):

Address:

City: State: Zip:

Home Phone: Birth Date: SS#:

Email Address:

Whom may we thank for referring you to our office?

Any family members treated in our office?

Responsible Party Information

Name: Marital Status:

Address: City: State: Zip:

Mailing Address (if different): City: State: Zip:

How long at this address: Home Phone: Work Phone:

Previous Address (if less than 3 years at current):

SS#: Birth Date: Relationship to Patient:

Employer: How Long Occupation:

Spouse's Name: Work Phone:

SS#: Birth Date: Relationship to Patient:

Employer: How Long: Occupation:

Financially Responsible Party Signature: X

Family Information (if patient is a minor)

The following information is requested so that we can communicate properly with the people involved with your child's treatment.

With whom does the patient live (custodial parent)?

Who should receive routine information about treatment progress?

Who should receive financial information?

Are the patient's parents ❑ Married ❑ Separated ❑ Divorced ❑ Remarried

Other adults we should know about:

Name: Relationship to Patient:

Home Phone: Work Phone:

Patient's Siblings (Names and Ages):

Orthodontic Insurance Information

Fill out this section if your dental insurance provides orthodontic benefits:

Insured's Name: Insured's SS#: Insured's ID#:

Insurance Company: Group No.: Employer:

Insurance Address & Phone:

If the Insured address is different than the above Responsible party, add:

Insured's Name: Insured's Birthdate:

Insured's Address:

Insured's SS# Insured's Phone:

Secondary Insurance Information: Insured's ID#:

Insured's Name: Insured's SS#: Insured's DOB:

Insurance Company: Group No.: Employer:

Insurance Address & Phone:

*If more dental insurance information, please use reverse side.

I understand a credit bureau report will be obtained.

Signature: X

(Parent or guardian if patient is a minor)

I've received a copy of the Notice of Privacy Practices.

Signature: X

(Parent or guardian if patient is a minor)