Paul DiFranco Orthodontics
10059 S. Roberts Road
Palos Hills, IL 60465

PATIENT INFORMATION

Name_____Date_____

Nickname_____

Birthdate_____/_____/_____Age_____ ☐ M ☐ F

Address_____

City_____State_____ Zipcode_____

Previous address (if less than 3 years)_____

_____

Home Phone_____

Dentist_____Last Visit_____

School_____Grade_____

Parent or Legal Guardian_____

Patient's Residence: ☐ Both Parents ☐ Mother ☐ Father

Other_____

In case of Emergency Contact_____

Phone #_____Relationship_____

INSURANCE INFORMATION ☐ YES ☐ NO

Primary Insurance Company_____

Policy Holder Name_____

Employer_____

Subscriber #_____Group #_____

Insurance Phone #_____

Secondary Insurance Company_____

Policy Holder Name_____

Employer_____

Subscriber #_____Group #_____

Insurance Phone #_____

MOTHER'S INFORMATION

☐ Mom ☐ Stepmom ☐ Guardian

Name_____

Birthdate_____/_____/_____

Address_____

City_____State_____Zipcode_____

Home Phone_____Work#_____

Cell Phone_____

Email_____

Employer_____Job title_____

No. of years employed_____Marital Status ☐ S ☐ M ☐ D

SSN_____

Are you the financially responsible party? ☐ YES ☐ NO

FATHER'S INFORMATION

☐ Dad ☐ Stepdad ☐ Guardian

Name_____

Birthdate_____/_____/_____

Address_____

City_____State_____ Zipcode_____

Home Phone_____Work#_____

Cell Phone_____

Email_____

Employer_____Job title_____

No. of years employed_____ Marital Status ☐ S ☐ M ☐ D

SSN_____

Are you the financially responsible party? ☐ YES ☐ NO

REFERRAL

WHO REFERRED YOU TO OUR OFFICE?

☐ Dentist_____

☐ Friend_____

☐ Online_____

☐ Other_____