



# Patient Registration

**Wood Orthodontics**  
CREATING SMILES FOR A LIFETIME

Welcome to Wood Orthodontics, P.C. We ask that you complete these forms with as much detail as possible. Please feel free to ask questions. Thank you!



## About the Patient

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Preferred Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ School \_\_\_\_\_ O Male O Female

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Email \_\_\_\_\_ Current Dentist \_\_\_\_\_

How did you hear about our office?  Friend \_\_\_\_\_  Dentist \_\_\_\_\_

Newspaper  Yellow Pages  Internet  Magazine  Other \_\_\_\_\_

## Persons Responsible for Account

Patient  Mother  Step Mother  Legal Guardian  Grandmother

Name:	Date of Birth:	Occupation:
Address:	Social Security #	Employer:
City, State, Zip:		For how long?
Home Phone:	Marital Status:	Work Phone:

Father  Step Father  Legal Guardian  Grandfather

Name:	Date of Birth:	Occupation:
Address:	Social Security #	Employer:
City, State, Zip:		For how long?
Home Phone:	Marital Status:	Work Phone:

## Emergency Information

In the case of an emergency where neither parent nor legal guardian can be reached, please identify the following information for the next **closest relative** not living with the patient.

Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_



*Dental Insurance Information*



Insurance Co. Name \_\_\_\_\_ Insurance Co. Phone \_\_\_\_\_  
 Group Number \_\_\_\_\_ Local Number \_\_\_\_\_ Policy Number \_\_\_\_\_  
 Who is the subscriber on this policy? \_\_\_\_\_ What is their SS# \_\_\_\_\_  
 Date of birth \_\_\_\_\_

Do you have Secondary Insurance?  Yes  No

Secondary Insurance Co. Name \_\_\_\_\_ Insurance Co. Phone \_\_\_\_\_  
 Group Number \_\_\_\_\_ Local Number \_\_\_\_\_ Policy Number \_\_\_\_\_  
 Who is the subscriber on this policy? \_\_\_\_\_ What is their SS# \_\_\_\_\_  
 Date of birth \_\_\_\_\_

**Requirement for filing Insurance Claims.** To precipitate the filing of my dental insurance claims, I do hereby authorize the release of confidential information to my dental insurance agency and understand that I am personally responsible for any balance remaining after the insurance payment has been received. I am also fully responsible if my insurance policy fails to pay, for any reason. I hereby authorize payment of insurance benefits directly to *Wood Orthodontics, P.C.* Furthermore, in the event of payment default for services previously rendered, I also agree to pay all reasonable collection and/or legal fees incurred in an attempt to collect on this amount. \_\_\_\_\_

*Initial*

\_\_\_\_\_  
*Signature of Parent of Legal Guardian*

\_\_\_\_\_  
*Date*