Wood Orthodontics
CREATING SMILES FOR A LIFETIME

Patient Registration

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!*

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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? O Yes O 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*