



Ebert Orthodontics

— Donna Ebert, D.D.S., M.D.S. —

YOUTH PATIENT INFORMATION

LAST NAME		FIRST NAME		MIDDLE NAME	PREFERRED NAME	SEX	BIRTH DATE	AGE
MAILING ADDRESS				CITY		STATE	ZIP CODE	
HOME PHONE			CELL PHONE		EMAIL			
SCHOOL (if student)	GRADE	PATIENT LIVES WITH MOTHER _____ FATHER _____ BOTH _____ OTHER _____						
WHO MAY WE THANK FOR RECOMMENDING US				NAME OF DENTIST		DATE OF LAST VISIT		
RELATED PATIENTS THAT ARE OR HAVE BEEN UNDER OUR CARE				NAMES & BIRTH DATES OF OTHER CHILDREN				
1.		1.		3.				
2.		2.		4.				

PARENT INFORMATION

Parents' relationship to each other: Married Divorced Separated Single Other

FATHER

Title Mr. Dr. Other

Name _____
Last First M.I.

Prefers to be called _____

ADDRESS (if different from patient's)

Street _____

City _____ State _____ Zip _____

How long at this address? _____

Previous Address if less than 2 years _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

The best number to contact me is: H _____ C _____ W _____

Employer _____ How Long? _____

Occupation _____

Dental Ins. _____

Dental Ins. I.D.# _____ Birthdate _____

SPOUSE

CUSTODY SOLE JOINT NONE

Any custody restrictions we need to be aware of? _____

MOTHER

Title Mrs. Ms. Dr. Other

Name _____

Prefers to be called _____

ADDRESS (if different from patient's)

Street _____

City _____ State _____ Zip _____

How long at this address? _____

Previous Address if less than 2 years _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

The best number to contact me is: H _____ C _____ W _____

Employer _____ How Long? _____

Occupation _____

Dental Ins. _____

Dental Ins. I.D.# _____ Birthdate _____

SPOUSE

CUSTODY SOLE JOINT NONE

Any custody restrictions we need to be aware of? _____

OTHER INSURED: NAME _____
Last First Middle

INSURANCE CO. _____ Dental Ins. ID# _____

EMERGENCY CONTACT INFORMATION

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU _____
Last First Relationship

ADDRESS _____ DAYTIME PHONE _____
Street City State Zip

To the best of my knowledge, the above information is complete and correct. I give my permission for the taking of photographs and necessary x-rays before, during and after treatment and to the use of photographs and records made in the process of examination, treatment and retention to be used for the purposes of demonstrations, office marketing, research, education or publication in professional journals.

Signature _____ Relationship to patient _____ Date _____