ROBINSON ORTHODONTICS
Jon N. Robinson, DMD, MS

Date _____ **Confidential Patient Information** A B C

Patient's Name _____ Male ☐ Female ☐
Last First Middle

Address _____ Email _____
Street City State Zip

Home Phone _____ Birthdate _____ School _____ Grade ____

If patient is a minor, give both parents or guardian's name(s) _____

Whom may we THANK for referring you to our office? _____

Confidential Responsible Party Information

Name _____ Marital Status _____
Last First Middle

Residence _____ Email _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home/Cell Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Birthday _____ Relationship to patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's/Other Parent's Name _____ Relationship to patient _____

Social Security # _____ Birthday _____ Home Phone _____ Cell Phone _____

Employer _____ Occupation _____ Work Phone _____ No. Years Employed ____

Insurance Information

Policy Holder's Name _____ DOB: _____ Soc.Sec.# _____

Insurance Company _____ Group No. _____ ID/Local Union No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Do you have secondary (dual) coverage? No ☐ Yes ☐ If yes, please fill out the secondary insurance information below.
Secondary Policy Holder's Name _____ DOB: _____ Soc.Sec.# _____

Insurance Company _____ Group No. _____ ID/Local Union No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

I hereby authorize payment directly to Jon N. Robinson, DMD MS _____ _____
Signature Date

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship to Patient _____

I understand that, where appropriate, credit bureau reports may be obtained. ***Signature*** _____