Northeast Orthodontic Specialists

Jacob Stadiem, DMD, MS

Date_____

Confidential Patient Information

A B C

Patient's Name _____ Called _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Age ____ Social Security # _____ Sex ___

If patient is a minor, give parent's or guardian's name _____

Sports or Hobbies _____ Whom may we thank for referring you? _____

Confidential Responsible Party Information

Name _____ Marital Status _____
Last First Middle

Residence _____ ☐ Own ☐ Rent
Street City State Zip

Mailing Address _____ Email _____
Street City State Zip

How long at this address _____ Previous Address _____
(if less than 3 yrs) Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Policy Holder's Name _____ and Soc.Sec. # _____

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

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Do you have dual coverage? No ☒ Yes ☒ If yes:

Policy Holder's Name _____ and Soc. Sec. # _____

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

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship _____

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

Signature (Parent's signature if minor) _____

Updates (date & initial) _____