West Orthodontics - Jerad L.West, D.D.S.

Today's Date: ____________

About the person desiring treatment:

Last Name: ______________________ First Name: _______________________ Birth date: _________ Male/Female

Home Address: ______________________________ City: _________________ State: ________ Zip: ____________

Mailing Address: _____________________________City: _________________ State: ________Zip: ____________

Home Phone: ____________________Cell Phone: ____________________ Email Address: ____________________

Please circle which option you prefer us to confirm appointments by: *Home Phone Cell Phone Other (specify)*

Dentist: ________________ Referred by: ________________ Family members seen in our office: ________________

If the patient is a minor:

Mother's Name: _________________________________ Father's Name: __________________________________

About the person primarily responsible for finances:

Last Name: ________________________ First Name: ___________________ Relationship: _____________________

Home Address: _______________________________ City: __________________ State: ________Zip ___________

Mailing Address: ______________________________ City: __________________ State: _______ Zip: ___________

Home Phone: ____________________ Work Phone: __________________ Ext.:_______ Cell Phone: ____________

Birth date: _____________Social Security # ___________________ Employer: ______________________________

Address: _______________________________City: _______________________State: ________Zip: ____________

Dental Insurance Co.:_______________________ Claims Address: ____

City: ____________________State: _______Zip: __________Phone: ____________________Group # ___________

Subscriber ID #______________________

About the person secondarily responsible:

Last Name: _______________________ First Name: ______________________ Relationship: ___________________

Home Address: _______________________________ City: ___________________ State: ________ Zip: __________

Mailing Address: ______________________________ City: ___________________ State: ________ Zip: _________

Home Phone: ___________________Work Phone: ___________________ Ext.:_______ Cell Phone: _____________

Birth date: ______________ Social Security #_____________________ Employer: ___________________________

Address: ______________________________ City: ________________________ State: ________ Zip: ___________

Dental Insurance Co.: __________________________ Claims Address: ____________________________________

City: _____________________ State: ______ Zip: _________ Phone: ____________________ Group #___________

Subscriber ID # _____________________________________