

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 # _____