GARFINKLE ORTHODONTICS

503.246.9802
info@garfinkleortho.com

HEALTH HISTORY AND INSURANCE UPDATE

PATIENT INFORMATION

Patient's Legal Name: _____ Patient's Biological Sex: _____

Patient's Preferred Name: _____ Patient's Preferred Pronouns: _____ Patient's DOB: _____

Address: _____ Primary phone: _____

Primary email: _____ Who is legally responsible for patient: _____

Dentist Name: _____ Any changes to health history? ◯ Yes ◯ No

Please explain: _____

_____

_____

PARENT/GUARDIAN #1

Name : _____

Relationship: _____ DOB: _____

Address: _____

Same as patient? (check if yes) ◯

Email (for appt reminders): _____

Home Phone: _____

Cell Phone: _____

Marital Status: _____

PARENT/GUARDIAN #2

Name : _____

Relationship: _____ DOB: _____

Address: _____

Same as patient? (check if yes) ◯

Email (for appt reminders): _____

Home Phone: _____

Cell Phone: _____

Marital Status: _____

DENTAL INSURANCE INFORMATION

In order to check benefits/bill insurance, we need a copy of your dental insurance card and the below information completed. Please text or email front/back photo of your dental insurance card to 503.246.9802 or bring the card to your appointment.

PRIMARY DENTAL INSURANCE:

Name of Insurance Company: _____ Phone: _____

Insurance Address: _____ Subscriber's Name: _____

SSN: _____ Sub ID: _____

Subscriber DOB: _____ Group or Policy Number: _____

Patient's Relationship to Subscriber: ◯ Self ◯ Spouse ◯ Dependent

SECONDARY DENTAL INSURANCE:

Name of Insurance Company: _____ Phone: _____

Insurance Address: _____ Subscriber's Name: _____

SSN: _____ Sub ID: _____

Subscriber DOB: _____ Group or Policy Number: _____

Patient's Relationship to Subscriber: ◯ Self ◯ Spouse ◯ Dependent