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Albuquerque, NM 87114
(505) 831-1600

HARNICK Orthodontics

WELCOME TO OUR OFFICE

Date _____

PATIENT'S NAME _____ ❑ **Male** ❑ **Female**
First **M.I.** **Last**

Nickname (optional) _____ **Date of Birth** _____ **Age** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

Phone # _____ **Daytime Phone # to confirm appts.#** _____ **Ask for** _____

Parent Name _____

Whom may we thank for referring you? (Dentist &/or Friend) _____

Name of friend or relative not living with you _____ **Phone #** _____

Address _____ **City** _____ **State** _____ **Zip** _____

School _____ **E-mail** **(Strictly Confidential)** _____

Names and ages of siblings _____

PRIMARY PERSON RESPONSIBLE FOR ACCOUNT

Name _____ **Relationship** _____ **Phone #** _____
First **M.I.** **Last**

Address _____ **City** _____ **State** _____ **Zip Code** _____

Social Security # (for Ins.) _____ **Drivers License #** _____ **Birthdate** _____

Employer's Name _____ **Phone #** _____ **Occupation** _____

Position _____ **Years Employed** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

Is primary person covered under an orthodontic insurance plan? ❑ **Yes** ❑ **No**
if yes: Name of Insurance Company _____ **Phone #** _____

Address _____

Local # _____ **Group #** _____ **Policy and/or ID#** _____

Secondary Orthodontic Insurance Coverage? ❑ Yes ❑ No

Name _____ **Relationship** _____ **Phone #** _____
First **M.I.** **Last**

Address _____ **City** _____ **State** _____ **Zip Code** _____

Social Security # (for Ins.) _____ **Drivers License #** _____ **Birthdate** _____

Employer's Name _____ **Phone #** _____ **Occupation** _____

Position _____ **Years Employed** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

Name of Insurance Company _____ **Phone #** _____

Address _____

Local # _____ **Group #** _____ **Policy and/or ID#** _____

PLEASE COMPLETE MEDICAL HISTORY ON BACK ⟶ **-OVER-**