

We are happy you're here!



CLARK BROWNE
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CHILD

A B C

Patient Information

Date _____ Age _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ / _____ / _____ Dentist _____

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

Whom may we thank for recommending our services? _____

Names and ages of children in family	Have any been seen in this office?	Yes	No
_____	_____	_____	_____
_____	_____	_____	_____

Responsible Party Information

Name _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Mobile _____ Work Phone _____

Previous Address (If less than 3 years) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ Number of years employed _____

Spouse's Name _____ Relationship to Patient _____

Employer _____
Last First Middle Occupation _____ Number of years employed _____

Social Security # _____ Birthdate _____ Work Phone _____ Mobile Phone _____

Responsible Party E-mail for appointment reminders etc. _____

Dental Insurance Information

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group Number _____ Birthdate _____

Insurance Company Address _____ Relationship to Patient _____

Insured's Employer _____ Contract Number _____

Do you have dual coverage? Yes No If yes:

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group Number _____ Birthdate _____

Insurance Company Address _____ Contract Number _____

Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Phone _____

To the best of my knowledge, the 2 pages of information (front and back) is complete and correct. I give my permission for any photographs, X-rays or study models to be used for displays at scientific presentations and/or publications of a scientific nature or for group purposes to further the art and science of orthodontics. I, the undersigned, agree to pay for attorney fees and other costs of collection in the event it becomes necessary to use attorney services to secure payment of this account. Also, I understand that where appropriate, credit bureau reports may be obtained.

_____ Date

_____ Signature of Patient or Parent or Guardian if Patient is a Minor

