Welcome

SANTA ANA ORTHODONTICS
Creating Beautiful Smiles

Date: _____

ID/DL #_____

SS#_____

Patient Information *(CONFIDENTIAL)*

Cell Phone _____

Name _____ Birthdate_____ Home Phone _____

Address _____ City_____ State_____ Zip Code_____

E-Mail Address_____

Check Box: Minor ○ Single ○ Married ○

Patient's Employer_____ Work Phone: _____

Employers Address_____ City_____ State_____ Zip _____

Person to contact in case of emergency _____ Phone_____

Insured/Parent

(Same As Above)

Name _____ Birthdate_____ Home Phone _____

Address _____ City_____ State_____ Zip Code_____

ID/DL # _____ SS#_____ Relationship To Patient_____

Patient's Employer_____ Work Phone: _____

Employers Address_____ City_____ State_____ Zip _____

Referral Information

Were you referred by one of our patients? ○ Yes ○ No

If Yes, Whom may we thank? _____

If No, How did you find our office? _____

HIPPA Acknowledgement

I have read and been offered a copy of the Santa Ana Dental Group Notice of Privacy Practices.

Signature of patient or parent (If minor) _____

Print name of patient or parent (If minor) _____ Date_____