John M. Pobanz, DDS, MS

We are pleased to welcome you to our office. We hope you will find a kind and comfortable atmosphere. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you!

PATIENT INFORMATION

Name ______________________________ Date ____________

Nickname ____________________________________

Birthdate ______/______/______ Age _________ ☐ M ☐ F

Address ____________________________________

City __________________ State ________Zipcode __________

Previous address (if less than 3 years) __________________

____

Home Phone __________________________________

Dentist _______________________ Last Visit_______________

Favorite Sports or Hobbies_____________________________

School _________________________ Grade _______________

Parent or Legal Guardian_______________________________

Patients Residence: ❑ Both Parents ❑ Mother ❑ Father

Other____

Incase of Emergency Contact ___________________________

INSURANCE INFORMATION ❑ YES ❑ NO

Primary Insurance Company_____________________________

Insured Name ____

Contact #_____________________ Group #_______________

Subscriber #__________________ Employer________________

Coverage Amount_________% up to _______ max _______ded

Secondary Insurance Name______________________________

Insured Name ____________________ Birthdate____/___/_____

Contact #______________________ Group #_______________

Subscriber #__________________ Employer________________

Coverage Amount ________% up to _______ max _______ ded

Third Insurance Company _______________________________

Insured Name_____________________________________

Contact #______________________ Group #_______________

Subscriber#___________________Employer________________

Coverage Amount ________% up to ________max _______ded

Orthodontics for kids of all ages!

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REFERRAL

WHO REFERRED YOU TO OUR OFFICE?

❑ Dentist ____________________________________

❑ Friend ____________________________________

❑ Yellow Pages_______________________________

❑ Other_____________________________________

MOTHER'S INFORMATION ❑Mom ❑StepMom ❑Guardian

Name _________________________ Birthdate ____/____/______

Address____

City____________________ State________ Zipcode __________

Home#_____________________ Wk #______________________

Employer___________________ Job title___________________

No. of years employed______________ Marital Status________

SSN_________________________ Cel #___________________

E-mail Address ____

FATHER'S INFORMATION ❑Dad ❑StepDad ❑Guardian

Name _________________________ Birthdate ____/____/______

Address____

City____________________ State________ Zipcode __________

Home#_____________________ Wk #______________________

Employer___________________ Job title___________________

No. of years employed______________ Marital Status________

SSN_________________________ Cel #___________________

E-mail Address ____

PERSON FINANCIALLY RESPONSIBLE FOR ACCT

Name ______________________ Relation__________________

Address____

City___________________State________ Zipcode __________

Home#_____________________ Wk #______________________

Employer___________________ Job title___________________

Please complete the Dental and Medical History on the back page. Thank you!