Kita Orthodontics
Patient and Parent Information

Patient Name: _____

Nick Name(s): _____Date of Birth: _____ Sex: _____
Address:_____ Apt#: _____
City: _____ State: _____ Zip Code: _____
Home Phone:_____ Work Phone:_____ Cell: _____
S.S.#: _____ Marital Status:_____
e-mail:_____
School (if student): _____ Grade: _____
Employer:_____ Occupation:_____
Address:_____
City: _____ State:_____ Zip: _____
Orthodontic Insurance Carrier:_____

Current Dentist: _____ Current Physician: _____
Whom may we thank for the Referral: _____

Parent Information:

Father's Name: _____
Address (if different from Patient's): _____
City:_____ State:_____ Zip: _____
Home Phone:_____ Work Phone:_____ Cell: _____
D.O.B.:_____SS Number:_____
e-mail:_____
Employer:_____ Occupation:_____
Address:_____City: _____ State:_____ Zip: _____
Orthodontic Insurance Carrier:_____

Mother's Name: _____
Address (if different from Patient's): _____
City:_____ State:_____ Zip: _____
Home Phone:_____ Work Phone:_____ Cell: _____
D.O.B.:_____SS Number:_____
e-mail:_____
Employer:_____ Occupation:_____
Address:_____
City: _____ State:_____ Zip: _____
Orthodontic Insurance Carrier:_____

INFORMATION ABOUT PERSON RESPONSIBLE FOR THIS ACCOUNT

Name: _____ Relationship to Patient: _____
Employed by/Occupation: _____
Mailing Address: _____
City: _____ State:_____ Zip: _____
Home Phone:_____ Work Phone:_____ Cell: _____

IF DIVORCE IS INVOLVED, WHO IS THE CUSTODIAL PARENT?_____
MAY PATIENT INFORMATION BE RELEASED TO THE NONCUSTODIAL PARENT? { } YES { } NO

PLEASE FILL OUT THE KITA ORTHODONTICS HEALTH HISTORY FORM