

Aces of Braces

(832) 720-3460 | acesofbraces.com

501 Gulf Fwy S, Suite 106 | League City, TX | 77573



Patient Information

NAME _____ PREFERRED NAME _____ M F

SSN _____ DOB _____ GRADE _____ SCHOOL ATTENDS _____

HOME PHONE _____ CELL PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

NAME/RELATIONSHIP OF PERSON ACCOMPANYING PATIENT TO CONSULT APPOINTMENT _____

PATIENT LIVES WITH WHOM/RELATIONSHIP _____

NAME OF SIBLINGS & AGES _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

Responsible Party

MARRIED SEPARATED DIVORCED WIDOWED SINGLE

MOTHER'S NAME _____	FATHER'S NAME _____
<input type="checkbox"/> PARENT <input type="checkbox"/> GUARDIAN <input type="checkbox"/> STEPMOTHER	<input type="checkbox"/> PARENT <input type="checkbox"/> GUARDIAN <input type="checkbox"/> STEPFATHER
DATE OF BIRTH _____ SSN _____	DATE OF BIRTH _____ SSN _____
ADDRESS _____	ADDRESS _____
CITY _____ STATE _____ ZIP _____	CITY _____ STATE _____ ZIP _____
HOW LONG AT THIS ADDRESS? _____	HOW LONG AT THIS ADDRESS? _____
CELL PHONE _____	CELL PHONE _____
WORK PHONE _____	WORK PHONE _____
EMPLOYER _____	EMPLOYER _____
OCCUPATION _____	OCCUPATION _____
EMAIL _____	EMAIL _____

Primary Dental Insurance

CHECK HERE IF NO ORTHODONTIC COVERAGE WILL BE APPLIED

INSURANCE COMPANY _____	INSURANCE PHONE NUMBER _____
EMPLOYER/GROUP NAME _____	GROUP NUMBER _____
SUBSCRIBER NAME _____	SUBSCRIBER ID _____
DATE OF BIRTH _____	RELATIONSHIP TO PATIENT _____

Secondary Dental Insurance

CHECK HERE IF NO SECONDARY INSURANCE

INSURANCE COMPANY _____	INSURANCE PHONE NUMBER _____
EMPLOYER/GROUP NAME _____	GROUP NUMBER _____
SUBSCRIBER NAME _____	SUBSCRIBER ID _____
DATE OF BIRTH _____	RELATIONSHIP TO PATIENT _____

Emergency Contact Information (OTHER THAN RESPONSIBLE PARTY)

NAME _____ RELATIONSHIP TO PATIENT _____

BEST PHONE _____

Please take a moment to complete the reverse side of this form.

