

Donald L. Simi, D.M.D.
Specialist in Orthodontics

Welcome to our office!

The following information is requested to enable us to give you a professional evaluation of your orthodontic concerns during your initial examination in our office. In order for Dr. Simi to thoroughly diagnose any condition, he must have accurate background and health information on which to base his decisions. This information, important for our records and your health, is confidential.

Patient's Name _____ Birthdate _____ Age ____ Sex F__ M__

Address _____ Telephone _____

Primary Email: _____

Patient's Occupation or School and Level _____

Patient's interests and/or hobbies _____

Who may we thank for referring you to our office? _____

Person to be contacted in case of emergency:

Name	Street	City/St/Zip	Phone
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IF PATIENT IS A DEPENDENT

Patient Living with: Mother __ Father __ Both __ Other __

Father's Name: _____ Address/Phone : Same as Patient's _____

Cell Phone: _____

Other: _____
Street City/St/Zip Phone

Occupation _____ Firm _____ Phone _____

Mother's Name _____ Address/Phone: Same as Patient's _____

Cell Phone: _____

Other: _____
Street City/St/Zip Phone

Occupation _____ Firm _____ Phone _____

If Patient is living with Other:

Street City/St/Zip Phone

FINANCIAL/INSURANCE INFORMATION

****Please provide us with your dental insurance card so that we may make a copy for our records****

Person RESPONSIBLE for this account: Mother __ Father __ Self __ Other __

Dental Insurance Co. _____ Group number _____

Subscriber's Name _____ Subscriber ID# _____

Subscriber's Date of Birth _____ Patient's Relationship to Subscriber __ Self __ Child __ Spouse

PLEASE ANSWER QUESTIONS ON REVERSE SIDE OF FORM →