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**

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 →