West Seattle Orthodontics Heidi K. Horwitz, DDS

Patient Information

Last Name: First Name: MI: Sex:

Prefers to be addressed as: Date of Birth: / / Age:

Address: Apt #:

City: State: Zip: Home Tel:

Email address:

Other Family Members Treated in this office:

If 18 years of age and older: □Single □Married □Widowed □Separated □Divorced Legal □Guardian

Employer: Phone Number:

□ Full Time □ Part Time □ Seasonal

Dental Insurance Information Please present your insurance card to the receptionist

Primary Insurance

Orthodontic Coverage: □Yes □No

Company:

City: State: Zip:

Insurance Tel: ( ) -

Group Number:

Subscriber's Name:

Date of Birth: / /

Subscriber's ID/SSN#

Relationship to Patient:

Employer:

Employer's Address:

Employers Address2:

City: State: Zip:

□ Full Time □ Part Time □ Seasonal

Secondary Insurance

Orthodontic Coverage: □Yes □No

Company:

City: State: Zip:

Insurance Tel: ( ) -

Group Number:

Subscriber's Name:

Date of Birth: / /

Subscriber's ID/SSN#

Relationship to Patient:

Employer:

Employer's Address:

Employers Address2:

City: State: Zip:

□ Full Time □ Part Time □ Seasonal

Parental/Guardian Information (If 17 years of age or younger)

Parent / Guardian

Last Name: First Name:

Phone Number:

E-mail Address:

□Single □Married □Widowed □Separated
□Divorced Legal □Guardian

Address:

Address2:

City: State: Zip:

Parent / Guardian

Last Name: First Name:

Phone Number:

E-mail Address:

□Single □Married □Widowed □Separated
□Divorced Legal □Guardian

Address:

Address2:

City: State: Zip:

Referral Information

How did you hear about Dr Horwitz: □Dentist □Family/Friend □Website □Other:______________________

- -

For office use only
Reviewed by:___________________________________