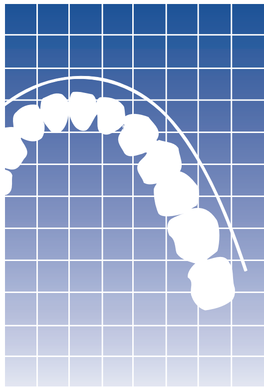

Larry
Majznerski
DDS, MSD, PC
SPECIALIST
IN ORTHODONTICS
& DENTOFACIAL
ORTHOPEDICS
Adults & Children

Patient Information Form

Date:____________________

Patient Information

Name ______________________________________ Preferred Name ______________ M ___ F ___
Last First M.I.

Birthdate ______________________________________ Age __________

Street Address ______________________ Apt# __________ City ______________________

State ______________________ Zip ______________________ Phone ______________________

E-mail ______________________ Cell Phone ______________________

✓ If member has had ortho treatment

Name & Age of Siblings ______________________________________ Age _____ ☐

______________________________________ Age _____ ☐

______________________________________ Age _____ ☐

Patient's School ______________________________________ Grade __________

If patient is a college student, please provide a residence address ______________________

____

How did you hear about our office? ______________________________________

Whom may we thank for referring you to our office? ______________________________________

Emergency Contact

Name ______________________________________ Relationship ______________________

Street Address ______________________ Apt# __________ City ______________________

State ______________________ Zip ______________________ Home Phone ______________________

Cell Phone ______________________ Work Phone ______________________

Personal History

Please list your hobbies/interests ______________________________________

____

____

(Over)

Responsible Party Information

Name ______________________________ Marital Status __________
Last First M.I.

Relationship to Patient ☐ self ☐ spouse ☐ parent ☐ guardian

Social Security # ______________________ D.O.B. __________

Street Address ______________ Apt# ________ City ______________

State __________ Zip __________ # of yrs. at this address ______

Previous address if less than 3 years ______________________

Home Phone ______________ Work Phone ______________

E-mail ______________ Cell Phone ______________

Employer ______________ Occupation ______________ # of yrs. ______

Spouse's Name ______________________________ Marital Status __________
Last First M.I.

Social Security # ______________________ D.O.B. __________

Street Address ______________ Apt# ________ City ______________

State __________ Zip __________ # of yrs. at this address ______

Previous address if less than 3 years ______________________

Home Phone ______________ Work Phone ______________

E-mail ______________ Cell Phone ______________

Employer ______________ Occupation ______________ # of yrs. ______

Dental / Orthodontic Insurance Information

Primary Insured's Name ______________ Social Security # ______________

Address if different from patient ______________________

Insurance Co. ______________________

Group # ______________ Member ID# ______________ D.O.B. __________

Insurance Co. Address ______________ Phone ______________

Insured's Employer ______________________

Do you have dual coverage? Yes______ No ______ If yes:

Secondary Insured's Name ______________ Social Security # ______________

Address if different from patient ______________________

Insurance Co. ______________________

Group # ______________ Member ID# ______________ D.O.B. __________

Insurance Co. Address ______________ Phone ______________

Insured's Employer ______________________

The information on this form is true and complete to the best of my knowledge.
I hereby authorize Dr. Majznerski's office to inquire as necessary into my credit history and standing.

Signature ______________________________ Date ______________