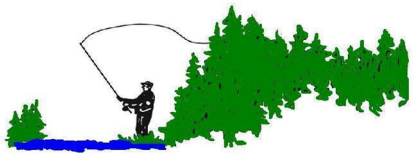

JOHN C. MATUNAS, D.D.S., P.A.

Specialist in Orthodontics

And Dentofacial Orthopedics for Children and Adults

Patient Information

Patient's Name _____
Last First Middle

Address _____
Street City State

Home Phone _____ **Date of Birth** _____ **Social Security #** _____

If patient is a minor, give parent / guardian's name _____

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

Responsible Party Information

Name _____ _____
Last First Middle Marital Status

Residence _____ **Own** ☐ **Rent** ☐ **Years**_____
Street City State Zip

Mailing Address _____
Street City State Zip

E-mail_____ **Home Phone**_____ **Cell**_____ **Work** _____

Previous Address (if less than 3 years) _____
Street City State Zip

Social Security # ---------- **Date of birth** _____ **Relationship to patient** _____

Employer _____ **Occupation**_____ **No. Years Employer**_____

Spouse's Name_____ **Date of Birth**_____

Spouse's Employer_____ **Work**_____ **Phone** _____

Occupation _____ **No. Years Employed** _____ **Social Security #** _____

Dental Insurance Information

PRIMARY INSURED'S NAME_____ **Soc. Sec. # / Plan ID #**_____

PRIMARY INSURANCE_____ **Group No.** _____ **Local No.** _____

Insurance Address _____ **Phone** _____

Do you have dual coverage? **Yes** ❑ **No** ❑

SECONDARY INSURED'S NAME_____ **Soc. Sec. # /Plan ID#** _____

SECONDARY INSURANCE _____ **Group No.** _____ **Local No.** _____

Insurance Address _____ **Phone** _____

Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____ **Cell/ Phone**_____

Complete Address _____

Signature _____ **Date** _____

Updates (dates & initials)_____ _____ _____ _____ _____

When appropriate, credit report will be obtained