Sheldon Peck Orthodontics
1792 W 1700 St., Ste. 201
Syracuse, UT 84075
Phone: 801-525-1333
Fax: 801-525-1448

Date_____

Confidential Patient Information

Patient's Name_____
Last First Middle

Address_____ Home Phone_____ Birthdate_____
Street City State Zip

If patient is a minor, give parent's or guardian's name_____

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

Confidential Responsible Party Information

Name_____Marital Status_____
Last First Middle

Residence_____ ☐ Own ☐ Rent
Street City State Zip

Mailing Address_____ Email_____
Street City State Zip

How long at this address_____ Previous Address_____
Street City State Zip

Home Phone_____ Work Phone_____ Cell Phone_____

Social Security #_____-_____-_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ No. Years Employed_____

Spouse's Name_____ Relationship to Patient_____
Last First Middle

Employer_____ Occupation_____ No. Years Employed_____

Social Security #_____-_____-_____ Birthdate_____ Work Phone_____

Insurance Information

Policy Holder's Name_____ Social Security #_____-_____-_____

Insurance Company_____ Grp. No._____ Identification No._____

Insurance Company Address_____ Ins. Co. Phone No_____

Policy Holder's Employer_____

Do you have dual coverage? ☐ No ☐ Yes If Yes:

Policy Holder's Name_____ Social Security #_____-_____-_____

Insurance Company_____ Grp. No._____ Identification No._____

Insurance Company Address_____ Ins. Co. Phone No_____

Policy Holder's Employer_____

Emergency Information

Name of nearest relative not living with you_____

Complete Address_____

Phone No_____ Relationship_____

I understand that where appropriate, credit bureau reports will be obtained.

Signature (Parent's signature if patient is a minor)_____

Updates (date & initial)_____