SHANNON HILGERS NISSEN
ORTHODONTICS

CHILD New Patient Form Page 1of 2

Welcome To Our Office!

Dr. Nissen may wish for you to have records taken for a more detailed diagnosis. These records would not be taken without your permission or shared with others under current HIPPA guidelines.

Personal:

Patient's Name: _____Age: _____
Address: _____ City: _____
State: _____Zip: _____ DOB: _____ Sex: M F
Home Phone: _____ Mother's Cell Phone: _____
Email address: _____Father's Cell Phone: _____
Has anyone in your family had orthodontic treatment? Yes _____ No _____
If yes, by whom? _____City/State: _____
Who is your child's General Dentist? _____City/State: _____
How did you hear about our office? How did you hear about our office? Google ____ Facebook ____Dentist Referral____ Patient Referral (If yes, by whom?):_____ Other:_____
Are you interested in: Braces _____ TMJ Therapy _____ Invisalign _____ Sleep Apnea_____

Parent Info:

Mother's Name: _____Mother's DOB: _____
Step Mother's Name _____ Step Mother's DOB: _____
Father's Name: _____Father's DOB: _____
Step Father's Name: _____ Step Father's DOB: _____
Is there any other person who may be bring your child to their appointments? Yes _____ No _____
Name: _____ Relationship to the patient? _____ Phone number: _____

Billing:

Do you have any Orthodontic Insurance Benefits? Yes _____No _____ If yes, please complete the following:
Subscriber: _____ Relationship to the patient: _____
Primary Insurance Company: _____ Employer: _____
Subscriber DOB: _____ Subscriber ID# or SSN#: _____
Insurance phone number: _____ Group #: _____
Do you have dual insurance? Yes _____ No _____ If yes, please complete the following:
Subscriber: _____Relationship to the patient: _____
Secondary Insurance Company: _____ Employer: _____
Subscriber DOB: _____ Subscriber ID# or SSN#: _____
Insurance phone number: _____ Group #: _____

I consent to photographs being taken of my child. That they may be used for illustration/ documentation of treatment.
Parent or Legal Guardian Signature: _____ Date: _____