EXAMINATION CARD

Eugenia Lee Orthodontics

Model No. _____

Patient Name (Last, First) _____ DOB _____

Date _____ Referred By_____ Sex _____

Home Address _____ City _____ Zip _____

Parent Name _____Phone_____

Email _____ Cell _____

Dentist _____ Phone_____

Medical Problem _____ Allergies _____

School _____ Grade _____ Hobbies_____

Financial Responsibility:

Name _____ Birthdate _____

Address _____ City _____ Zip _____

Relationship to Patient _____Phone _____ Cell _____

Employer _____ Occupation _____

Insurance Co _____ Member ID #/SS _____ Group #_____