Richard J. Hoskinson, DDS
Specialist in Orthodontics
518-372-3424

207 Mohawk Avenue
Suite 1A
Scotia, NY 12302

Patient Information

***Name*_____*Birthdate*_____**
***Address*_____*Phone*_____**

First Visit Date_____

School_____Grade_____Interests_____

Chief Complaint_____

Referred by_____

Prior Orthodontics_____

Father's Name_____

Social Security #_____ DOB_____

Address_____

_____

Phone H_____W_____ C_____

Mother's Name_____

Social Security #_____DOB_____

Address (or, same as above □)_____

_____

Phone H_____ W_____ C_____

Parent's Status: □ Married □ Separated □ Divorced □ Widowed □ Single

If patient does not live with both parents, with whom does patient live?
□ Father □ Mother □ other, _____

_____

Person Responsible for this account: □ Father □ Mother □ Other_____

Address (if different than mother/father):_____

_____

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Please complete if patient has Orthodontic Insurance coverage. If necessary, please contact your insurance company to confirm Orthodontic coverage.

Name_____Birthdate_____
Address_____
_____

Primary Insurance

Insured's Name_____

Date of Birth_____ Social Security #_____

Employer_____

Address_____Ph.#_____

Insurance Company (orthodontic only)_____

Address_____

_____

Phone #_____ ID #_____

Insured's Signature (to be kept on file)_____

Secondary Insurance

Insured's Name_____

Date of Birth_____Social Security #_____

Employer_____

Address_____Ph. #_____

Insurance Company(orthodontic only)_____

Address_____

_____

Phone #_____ ID #_____

Insured's Signature (to be kept on file)_____