

NA ORTHODONTICS

Child new-patient demographic form · Under 18 / dependent

North Arlington: 201.991.4447 | Jersey City: 201-940-1555

Please complete and bring to your appointment. Do not send completed forms by ordinary email.

PATIENT INFORMATION

Patient first name	Patient last name
Patient date of birth	Nickname / preferred name
Gender / identity	
☐ Male ☐ Female ☐ Non-binary ☐ Self-describe ☐ Prefer not to say	
Patient street address	Patient city
Patient state	Patient ZIP
Patient cell phone	Patient email
Allow patient portal access for the minor?	
☐ Yes ☐ No	
Patient's dentist	Who referred the patient?
Has anyone in the family been seen at NA Orthodontics?	
☐ Yes ☐ No	

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Patient name: _____

PARENT 1

Parent 1 first name	Parent 1 last name
_____	_____
Parent 1 email	Parent 1 cell phone
_____	_____
Parent 1 employer	Parent 1 occupation
_____	_____
Parent 1 marital status	

PARENT 2

Parent 2 first name	Parent 2 last name
_____	_____
Parent 2 email	Parent 2 cell phone
_____	_____
Parent 2 employer	Parent 2 occupation
_____	_____
Parent 2 marital status	

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CONTACT PREFERENCES

Appointment reminders

- ☐ Parent 1 text message
- ☐ Parent 1 email
- ☐ Parent 2 text message
- ☐ Parent 2 email
- ☐ Patient text message
- ☐ Patient email
- ☐ Other

Other contact preference

Who does the patient live with?

Names and ages of siblings

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BILLING PARTY

If the billing party is the patient or a listed parent, skip their duplicate details.

Complete a separate billing address only if different from the patient's.

Who is responsible for billing?

☐ Parent 1 ☐ Parent 2 ☐ Someone else

Billing party first name

Billing party cell phone

Billing party email

Billing party employer

Same address as patient?

☐ Yes ☐ No

Billing party street address

Billing party state

Billing party last name

Billing party home phone

Billing party occupation

Billing party city

Billing party ZIP

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DENTAL INSURANCE

Complete insurance details only if coverage is available. Secondary coverage is optional.

Social Security numbers are intentionally omitted; contact the office if needed.

Does the patient have dental insurance?

☐ Yes ☐ No

Primary dental insurance name

Primary subscriber name

Relationship to subscriber

Primary subscriber date of birth

Primary insurance patient policy / member ID

Secondary dental insurance?

☐ Yes ☐ No

Secondary insurance name

Secondary subscriber name

Secondary subscriber date of birth

Secondary subscriber member ID

ACKNOWLEDGMENT

The above information is true to the best of my knowledge, and I understand that it is my obligation to update this information as it changes.

Signer's full name

Relationship to patient

Date signed

Signature: _____