

# Ronald P. Kolodziej, D.M.D., M.S., L.L.C.

## PATIENT DATA

Patient name \_\_\_\_\_ Date \_\_\_\_\_  
*first middle last*

Address \_\_\_\_\_  
*street city zip code*

Is there a name other than your first name that you prefer to be called? \_\_\_\_\_

Birthdate \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_ Phone \_\_\_\_\_ May we text appointment reminders to you? Y N

Alternate phone \_\_\_\_\_ Preferred time of day to be contacted \_\_\_\_\_

E-mail address for appointment reminders, etc. \_\_\_\_\_

Sex assigned on birth certificate \_\_\_\_\_ Current gender identification \_\_\_\_\_ Preferred pronouns \_\_\_\_\_

Physician \_\_\_\_\_ Location \_\_\_\_\_ Date of last visit \_\_\_\_\_

Dentist \_\_\_\_\_ Location \_\_\_\_\_ Date of last visit \_\_\_\_\_

How did you discover our practice? \_\_\_\_\_

Do you anticipate moving out of the area or the need to transfer to a different orthodontist within the next 16 months? Y N

Does the patient have orthodontic insurance? Y N If yes, name of carrier: \_\_\_\_\_

Please explain why you are considering treatment: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **For patients over 18 years of age:**

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Emergency contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Marital status \_\_\_\_\_ Who will be financially responsible for this account? \_\_\_\_\_ \*

### **For patients under 18 years of age:**

Patient's school \_\_\_\_\_

Parent/Guardian/Father's name \_\_\_\_\_ Phone (if different from above) \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Parent/Guardian/Mother's name \_\_\_\_\_ Phone (if different from above) \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Who will be financially responsible for this account? \_\_\_\_\_

\*Financially responsible person's phone/ address if different from parent/guardian \_\_\_\_\_

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