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Patient Information					A	B	C
Date _____			Email Address _____				
Patient's Name _____		Last	First	Middle			
Address _____		Street	City	State	Zip		
Nickname _____	Birthdate _____	Age _____	Sex _____	Social Security # _____			
If patient is a minor, give parent or guardians' name _____							
Whom may we thank for referring you to our office? _____							

Responsible Party Information					
Name _____		Last	First	Middle	Marital Status
Residence _____		Street	City	State	Zip
Mailing Address _____		Street	City	State	Zip
How long at this address? _____	Home Phone _____	Cell Phone _____	Work Phone _____		
Previous Address (if less than 3 yrs) _____		Street	City	State	Zip
Social Security # _____	Birthdate _____	Relationship to Patient _____			
Employer _____	Occupation _____	No. Years Employed _____			
Spouse's Name _____		Last	First	Middle	Relationship to Patient _____
Employer _____	Occupation _____	No. Years Employed _____			
Social Security # _____	Birthdate _____	Work Phone _____			

Insurance Information	
Insured's Name _____	Insured's Social Security # _____
Insurance Company _____	Group Number _____
Insurance Co. Address _____	Phone _____
Insured's Employer _____	
Do you have secondary coverage? (circle one) YES NO If yes: _____	
Insured's Name _____	Insured's Social Security # _____
Insurance Company _____	Group Number _____
Insurance Co. Address _____	Phone _____
Insured's Employer _____	