**Jacksonville University**
**2800 University Blvd. North**
**Jacksonville, FL 32211**

**School of Orthodontics**
**Phone: 904-256-7846**
**www.jusmiles.com**

# Patient Information – CHILD

Patient's Name: ________________________________________Nickname:__________________ Gender: [ ] M [ ] F
Address: Street: __________________________________________________________________Apt./Unit___________
City _____________________________________________________________State: ______________ Zip:__________
Home Phone: ( ) __________________________________Cell Phone: ( )________________________________
Patient's D.O.B.: __________________________________

**Please list the name and address of the person who will be Financially Responsible for treatment: (Contractee)**
Name: ___________________________________ Address __________________________________________________
(H) Phone: ( ) ____________________ (W) Phone: ( ) _______________________ Cell: ( ) ________________
Date of Birth: ____________________________________ Soc. Security #_____________________________________
Relationship to Patient: ______________________ E mail Address ____________________________________________

**Mother's Contact Information**
Name: _____________________________________________________________________________________________
Address: ___________________________________________________________________________________________
City/State/Zip: _____________________________________________________________________________________
Phone (H): ________________________________ Phone (C): ____________________ (W): ______________________
Drivers License #: ____________________________________ Date-of –Birth:__________________________________
Soc. Security #: _____________________________________ Email: ________________________________________

**Father's Contact Information**
Name: _____________________________________________________________________________________________
Address: ___________________________________________________________________________________________
City/State/Zip: _____________________________________________________________________________________
Phone (H): ________________________________ Phone (C): ____________________ (W): ______________________
Drivers License #: ____________________________________ Date of –Birth:__________________________________
Soc. Security #: _____________________________________ Email: ________________________________________

**Parents' marital status**: [ ] Married [ ] Divorced [ ] Separated
**Who is/are the legal guardian**: [ ] Joint [ ] Mother [ ] Father [ ] Other ______________________________
Will a non custodial adult be bringing the patient in for his or her appointment? __________________________
Are we treating other family members? [ ] Y [ ] N Name of Family Member: __________________________

I understand that this information is correct, that it will be used for my benefit and that Jacksonville University is relying on its accuracy. I am responsible for providing Jacksonville University with any necessary information, changes in information, and prompt completion of forms. I understand that in the event that financial obligations cannot be met, JU has the right to terminate treatment on my child regardless of whether or not the treatment objectives have been met.

______________________________________________________________ ______________________
Signature of Parent/Guardian Date

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FOR OFFICE USE ONLY

**TRAD** Type A_____ Type B_____ Phase I______ LTD/PART________ Ceramic_______

**INV / LING** Type A_____ Type C______

**OTHER** ____________________________________________ ______________________________
**FACULTY**