



DEMKO ORTHODONTICS

Orthodontics & Dentofacial Orthopedics Adults & Adolescents

JACQUELINE ANNE DEMKO, D.D.S., M.S.

CHESTERFIELD • 14377 Woodlake Dr. #216 • Chesterfield, MO 63017 • (314) 576-4955

ST. CHARLES • 2745 West Clay, Suite G • St. Charles, MO 63301-2583 • (636) 946-6503

WASHINGTON • 904 S. Jefferson St. • Washington, MO 63090 • (636) 239-2272

PATIENT INFORMATION

Date _____

www.DemkoSmiles.com

Patient's Full Name _____ Prefers to be Called _____
First, Middle, Last

Patient's Address _____ Home Phone () _____
Street City State Zip

Patient's Birthday ____/____/____ Age ____ Male Female Cell Phone () _____
Month Day Year

Patient's Dentist _____
Name, City, State, Phone No.

Whom may we thank for referring you? _____ Other family members seen by us _____

Children and ages of siblings _____ E-mail _____

RESPONSIBLE PARTY INFORMATION

Name _____ Married Single Divorced Home Phone () _____
First, Middle, Last

Home Address _____ No. of Years at Address _____
Street City State Zip

Your Relationship to Patient _____ Your Birthday ____/____/____ Email _____
Month Day Year

Your Employer _____ Social Security No. ____/____/____

Your Occupation _____ Work Phone () _____ Cell Phone () _____ No. of Years Employed ____

Spouse's Name _____ Spouse's Birthday ____/____/____ Email _____
First, Middle, Last Month Day Year

Spouse's Employer _____ Work Phone () _____ Cell Phone () _____

Spouse's Occupation _____ Social Security No. ____/____/____ No. of Years Employed ____

INSURANCE INFORMATION

Primary Orthodontic Insurance

Subscriber's Name _____

Social Security No. ____/____/____

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone No. _____

Group No. (Plan, Local, or Policy No.) _____

Relationship to Patient _____

Subscriber's Birthday ____/____/____
Month Day Year

Subscriber's Employer _____

I have been informed of the treatment plan. I authorize release of any information related to this claim.

Signed (Patient, or Parent if Minor)

Date

I hereby authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me.

Signed (Insured Person)

Date

Secondary Orthodontic Insurance

Subscriber's Name _____

Social Security No. ____/____/____

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone No. _____

Group No. (Plan, Local, or Policy No.) _____

Relationship to Patient _____

Subscriber's Birthday ____/____/____
Month Day Year

Subscriber's Employer _____

I have been informed of the treatment plan. I authorize release of any information related to this claim.

Signed (Patient, or Parent if Minor)

Date

I hereby authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me.

Signed (Insured Person)

Date

