



James W. Logeman, D.D.S., M.S. ORTHODONTICS

PRACTICE LIMITED TO ORTHODONTICS

5240 East Galbraith Road
Cincinnati, Ohio 45236
(513) 791-0260

www.orthodude.com

318 Reading Road
Mason, Ohio 45040
(513) 398-0133

Please take a few minutes to thoroughly complete this form, thank you.

Child Information

Date: _____

Patient's Name (last, first Middle) _____ Nick Name: _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Age _____

Siblings Name and age _____

Other family members seen by us _____

School _____ Hobbies/Interests _____

Whom may we thank for referring you to our office? _____

Dentist _____

Previous Orthodontic Treatment? Yes No With whom? _____

Dental Concerns _____ Allergies _____

Special and/or Medical circumstances you would like to share? _____

Parent Information: Marital Status? **Married** **Separated** **Divorced** **Widowed**

Father's Name (last, first, MI) _____

Mailing Address (if different) _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____ Work Phone _____

Email Address: _____ Date of Birth _____

Employer _____ Occupation _____

Mother's Name (last, first, MI) _____

Mailing Address (if different) _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____ Work Phone _____

Email Address: _____ Date of Birth _____

Employer _____ Occupation _____

Insurance Information

Insured's Name _____ Relationship to Patient _____

Insured's DOB _____ Social Security Number _____

Primary Dental Insurance Company: _____

Insurance Claims Address _____ State _____ Zip _____

Phone _____

Group Number: _____ ID Number: _____

Employer: _____

Orthodontic Lifetime Max: _____ Amount Used: _____

Insured's Name _____ Relationship to Patient _____

Insured's DOB _____ Social Security Number _____

Secondary Dental Insurance Company: _____

Insurance Claims Address _____ State _____ Zip _____

Phone _____

Group Number: _____ ID Number: _____

Employer: _____

Orthodontic Lifetime Max: _____ Amount Used: _____

Emergency Information

Name and relationship of nearest emergency contact not living with you _____

Address _____ Phone _____

I authorize release of insurance information, Printed Name _____

Signature _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature _____