

# KIMBROUGH ORTHODONTICS

Date \_\_\_\_\_

WILLIAM A. KIMBROUGH, D.D.S., M.S., INC.  
AMERICAN BOARD OF ORTHODONTICS CERTIFIED

1542 Green Oak Place  
Kingwood, TX 77339

281-358-8551  
Fax 281-358-0230

## 1 BEGIN HERE: PATIENT INFORMATION

Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ Birthday: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## 2 GENERAL INFORMATION

### FATHER or SELF GUARDIAN INFORMATION

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_  
Birthday: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Driver's License #: \_\_\_\_\_ SS#: \_\_\_\_\_  
How Long at this Address \_\_\_\_\_ How long at Previous Address \_\_\_\_\_

### EMPLOYER/INSURANCE INFORMATION

Employer Name: \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Number of Years Employed \_\_\_\_\_ Occupation \_\_\_\_\_  
Dental Insurance Name: \_\_\_\_\_  
Insurance Address: \_\_\_\_\_  
Insurance City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Insurance Phone: ( ) \_\_\_\_\_ ext: \_\_\_\_\_  
Group #: \_\_\_\_\_ Local or Union #: \_\_\_\_\_

### MOTHER or SPOUSE INFORMATION

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_  
Birthday: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Driver's License #: \_\_\_\_\_ SS#: \_\_\_\_\_  
How Long at this Address \_\_\_\_\_ How long at Previous Address \_\_\_\_\_

### EMPLOYER/INSURANCE INFORMATION

Employer Name: \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Number of Years Employed \_\_\_\_\_ Occupation \_\_\_\_\_  
Dental Insurance Name: \_\_\_\_\_  
Insurance Address: \_\_\_\_\_  
Insurance City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Insurance Phone: ( ) \_\_\_\_\_ ext: \_\_\_\_\_  
Group #: \_\_\_\_\_ Local or Union #: \_\_\_\_\_

## 3 OTHER INFORMATION

Who is the Responsible Party: \_\_\_\_\_ Who may we thank for referring you? \_\_\_\_\_  
Dentist Name: \_\_\_\_\_ Sp or Hobbies: \_\_\_\_\_  
Address: \_\_\_\_\_ Sch l Name: \_\_\_\_\_ Grade: \_\_\_\_\_  
Physician Name: \_\_\_\_\_ Nu er of Brothers: \_\_\_\_\_ Ages: \_\_\_\_\_  
Address: \_\_\_\_\_ Nu er of Sisters: \_\_\_\_\_ Ages: \_\_\_\_\_

