



American
Association of
Orthodontists®

My Life. My Smile. My Orthodontist.®

Medical Dental History Form for Patients Under Age 18

all
about
smiles
Orthodontics and Dentofacial Orthopedics

CONFIDENTIAL

PATIENT

Date _____

Patient's last name _____ First name _____ Middle initial _____

Prefers to be called _____ Hobbies, activities _____

Birth date _____ Sex ☐ Male ☐ Female Social Security # _____

School _____ Grade _____ Email address(es) _____

Home address _____ City, State, Zip code _____

Home phone () _____ - _____ Cell phone () _____ - _____

PARENT/GUARDIAN

Custodial parent(s) name(s) _____

Patient lives with (check all that apply) ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Grandparent(s) ☐ Other _____

Father's full name _____ Title: ☐ Mr ☐ Dr ☐ Other _____

Occupation _____ Email address _____

Address (if different) _____

Home phone (if different) () _____ - _____ Cell phone () _____ - _____ Work phone () _____ - _____

Mother's full name _____ Title: ☐ Mrs ☐ Ms ☐ Dr ☐ Other _____

Occupation _____ Email address _____

Address (if different) _____

Home Phone (if different) () _____ - _____ Cell phone () _____ - _____ Work phone () _____ - _____

DENTIST

Patient's Dentist _____ Address, City, State _____

Last seen _____ Reason _____ Next appointment _____

Other dentists/dental specialists now being seen: Name _____ City, State _____

Reason _____

GENERAL INFORMATION

What concerns you about your child's teeth? _____

What concerns your child about his/her teeth? _____

How does your child feel about orthodontic treatment? _____

Who suggested that your child might need orthodontic treatment? _____

Why did you select our office? _____

Describe any previous orthodontic treatment or consultations. _____

Does your child play a musical instrument? _____

Brother/sister name _____ age _____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____
Brother/sister name _____ age _____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____
Brother/sister name _____ age _____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____
Brother/sister name _____ age _____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____
Have any other family members been treated in this office? Please name them. _____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____
Address (if different than page 1) _____ City, State, Zip _____
Home phone () _____ - _____ Cell phone () _____ - _____ Email address(es) _____
Social Security # _____ Employer _____
Who will be responsible for bringing the patient to orthodontic appointments? _____

DENTAL INSURANCE

Primary policy holder's full name _____ Birth date _____
Social Security # _____ Relationship to patient _____
Address and phone (if not listed above) _____
Employer _____ Address _____
Insurance company _____ Group # _____ ID# _____
Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know

Secondary policy holder's full name _____ Birth date _____
Social Security # _____ Relationship to patient _____
Address and phone (if not listed above) _____
Employer _____ Address _____
Insurance company _____ Group # _____ ID# _____
Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know

MEDICAL INSURANCE

Policy holder's full name _____
Insurance Company _____

PHYSICIAN

Patient's Physician _____ City, State _____
Last seen _____ Reason _____ Next appointment _____
Most recent physical exam _____

Other physicians/health care providers being seen now:

Name _____ City, State _____
Reason _____
Name _____ City, State _____
Reason _____

Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation.

For the following questions, please mark yes, no, or don't know/understand (dk/u).

MEDICAL HISTORY

Now or in the past, has your child had:

Yes No DK/U

- ☐ ☐ ☐ Birth defects or hereditary problems?
- ☐ ☐ ☐ Bone fractures or major injuries?
- ☐ ☐ ☐ Any injuries to face, head, neck?
- ☐ ☐ ☐ Arthritis or joint problems?
- ☐ ☐ ☐ Cancer, tumor, radiation treatment or chemotherapy?
- ☐ ☐ ☐ Endocrine or thyroid problems?
- ☐ ☐ ☐ Diabetes or low sugar?
- ☐ ☐ ☐ Kidney problems?
- ☐ ☐ ☐ Immune system problems?
- ☐ ☐ ☐ History of osteoporosis?
- ☐ ☐ ☐ Gonorrhea, syphilis, herpes, sexually transmitted diseases?
- ☐ ☐ ☐ AIDS or HIV positive?
- ☐ ☐ ☐ Hepatitis, jaundice, or other liver problems?
- ☐ ☐ ☐ Polio, mononucleosis, tuberculosis, pneumonia?
- ☐ ☐ ☐ Seizures, fainting spells, neurologic problems?
- ☐ ☐ ☐ Mental health disturbance or depression?
- ☐ ☐ ☐ History of eating disorder (anorexia, bulimia)?
- ☐ ☐ ☐ Frequent headaches or migraines?
- ☐ ☐ ☐ High or low blood pressure?
- ☐ ☐ ☐ Excessive bleeding or bruising, anemia?
- ☐ ☐ ☐ Chest pain, shortness of breath, tire easily, swollen ankles?
- ☐ ☐ ☐ Heart defects, heart murmur, rheumatic heart disease?
- ☐ ☐ ☐ Angina, arteriosclerosis, stroke or heart attack?
- ☐ ☐ ☐ Skin disorder (other than common acne)?
- ☐ ☐ ☐ Does your child eat a well-balanced diet?
- ☐ ☐ ☐ Vision, hearing, or speech problems?
- ☐ ☐ ☐ Frequent ear infections, colds, throat infections?
- ☐ ☐ ☐ Asthma, sinus problems, hayfever?
- ☐ ☐ ☐ Tonsil or adenoid condition?
- ☐ ☐ ☐ Does your child frequently breathe through his/her mouth?
- ☐ ☐ ☐ Has your child ever taken intravenous bisphosphonates such as Zometa (zoledronic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?
- ☐ ☐ ☐ Has your child ever taken oral bisphosphonates such as Fosamax (alendronate), Actonel (risedronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone disorders?

Has your child had allergies or reactions to any of the following?

Yes No DK/U

- ☐ ☐ ☐ Local anesthetics (novocaine, lidocaine, xylocaine)
- ☐ ☐ ☐ Latex (gloves, balloons)
- ☐ ☐ ☐ Aspirin
- ☐ ☐ ☐ Ibuprofen (Motrin, Advil)
- ☐ ☐ ☐ Penicillin
- ☐ ☐ ☐ Other antibiotics
- ☐ ☐ ☐ Metals (jewelry, clothing snaps)
- ☐ ☐ ☐ Acrylics
- ☐ ☐ ☐ Plant pollens
- ☐ ☐ ☐ Animals
- ☐ ☐ ☐ Foods
- ☐ ☐ ☐ Other substances _____

DENTAL HISTORY

Now or in the past, has your child had:

Yes No DK/U

- ☐ ☐ ☐ Erupting teeth very early or very late?
- ☐ ☐ ☐ Primary (baby) teeth removed that were not loose?
- ☐ ☐ ☐ Permanent or extra (supernumerary) teeth removed?
- ☐ ☐ ☐ Supernumerary (extra) or congenitally missing teeth?
- ☐ ☐ ☐ Chipped or injured primary or permanent teeth?
- ☐ ☐ ☐ Any sensitive or sore teeth?
- ☐ ☐ ☐ Any lost or broken fillings?
- ☐ ☐ ☐ Jaw fractures, cysts, infections?
- ☐ ☐ ☐ Any teeth treated with root canals or pulpotomies?
- ☐ ☐ ☐ Frequent canker sores or cold sores?
- ☐ ☐ ☐ History of speech problems or speech therapy?
- ☐ ☐ ☐ Difficulty breathing through nose?
- ☐ ☐ ☐ Mouth breathing habit or snoring at night?
- ☐ ☐ ☐ History of speech problems?
- ☐ ☐ ☐ Frequent oral habits (sucking finger, chewing pen, etc)?
- ☐ ☐ ☐ Teeth causing irritation to lip, cheek or gums?
- ☐ ☐ ☐ Tooth grinding or clenching?
- ☐ ☐ ☐ Clicking, locking in jaw joints?
- ☐ ☐ ☐ Soreness in jaw muscles or face muscles?
- ☐ ☐ ☐ Has your child been treated for "TMJ" or "TMD" problems?
- ☐ ☐ ☐ Any broken or missing fillings?
- ☐ ☐ ☐ Any serious trouble associated with previous dental treatment?
- ☐ ☐ ☐ Has your child ever been diagnosed with gum disease or pyorrhea?

PATIENT HEALTH INFORMATION

Do you think that any of your child's activities affect his/her face, teeth or jaws? How? _____

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that your child takes.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Does your child take antibiotic pre-medication before any dental procedures? _____

Does your child have (or ever had) a substance abuse problem? _____

Does your child chew or smoke tobacco? _____

Have you noticed any unusual changes in your child's face or jaws? _____

Any other physical problems? _____

FAMILY MEDICAL HISTORY

Have the parents or siblings ever had any of the following health problems? If so, please explain.

Bleeding disorders _____ Diabetes _____

Arthritis _____ Severe allergies _____

Unusual dental problems _____ Jaw size imbalance _____

Other family medical conditions? _____

How often does your child brush? _____ Floss? _____

RELEASE AND WAIVER

I authorize release of any information regarding my child's orthodontic treatment to my dental and/or medical insurance company.

Parent/Guardian Signature _____ Date _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my child's medical or dental health.

Parent/Guardian Signature _____ Date _____

MEDICAL HISTORY UPDATES OR CHANGES

Changes _____

Parent/Guardian Signature _____ Date _____

Dental Staff Signature _____ Date _____

Changes _____

Parent/Guardian Signature _____ Date _____

Dental Staff Signature _____ Date _____

Changes _____

Parent/Guardian Signature _____ Date _____

Dental Staff Signature _____ Date _____



SCHEDULING INFORMATION

Our scheduling system has several goals: We want to see you on time for your appointment and we want to have plenty of time during each appointment to do the necessary treatments, to give you information about your treatment, and to answer any questions. We also want to work with you around your school and work hours as much as possible. Therefore we need both structure and flexibility in our scheduling system.

Here are some aspects of the scheduling system that we feel are important:

Between 2:00 pm and 4:30 pm we schedule many short appointments so that as many patients as possible do not have to miss school or work. We provide school/work excuses for orthodontic appointments.

Arriving Late: Because the schedule is carefully crafted, your late arrival can cause a problem in the flow of the appointments. In fairness to all other scheduled patients, we will most likely offer to reschedule your appointment. If you choose to wait and be seen, you will have to wait until all other patients that arrived on time are seen.

Long Appointments: These are more detailed and technique-sensitive appointments. For this reason these appointments will be scheduled during our morning hours.

Repairs: These appointments are scheduled during morning hours.

Broken Appointments: We can usually re-schedule a missed appointment in the morning. You might have to wait 6-8 weeks for an after school/work appointment, since they are scheduled that far in advance.

Short Appointments: You may be amazed, concerned or confused about how short some of the appointments are. We often must see the patient for a short visit to monitor tooth movement without making complex adjustments.

We thank you in advance for your cooperation.

I have read and understand the All About Smiles scheduling policies.

Signature

Date



MEDIA RELEASE CONSENT FORM

I, _____, hereby agree and give my permission for **All About Smiles Orthodontics**, and their respective orthodontists (hereby referred to as **All About Smiles Orthodontics**) to use pictures of my smile, both before and after, in the capacity of case presentation. I understand that my photos, both before and after, may be used in:

~ Social media posts (Instagram and Facebook), company website gallery, as well as in-office photography, including displays in the waiting room, treatment areas, and in a compilation book for case presentations.

I understand that these photos will not be used for any other commercial purposes without my written consent.

By selecting the appropriate box below, I grant my permission in the following manner:

☐ I authorize and permit **All About Smiles Orthodontics** to use my smile photos, full-face photos, first name, and a brief story about my smile in all forms of media release as outlined above.

☐ I authorize and permit **All About Smiles Orthodontics** to use my smile photos, full-face photos, and first name but no brief story about my smile in all forms of media release as outlined above.

☐ I authorize and permit **All About Smiles Orthodontics** to use only my smile photos, but not my first name in all forms of media release as outlined above.

Patient name (print): _____ **Date:** _____

Signature: _____ **Relationship to patient:** _____
(Patient, Legal Guardian, or Authorized Representative)

INFORMED CONSENT

for the Orthodontic Patient **Risks and Limitations of Orthodontic Treatment**

Successful orthodontic treatment is a partnership between the orthodontist and the patient. The doctor and staff are dedicated to achieving the best possible result for each patient. As a general rule, informed and cooperative patients can achieve positive orthodontic results. While recognizing the benefits of a beautiful healthy smile, you should also be aware that, as with all healing arts, orthodontic treatment has limitations and potential risks. These are seldom serious enough to indicate that you should not

have treatment; however, all patients should seriously consider the option of no orthodontic treatment at all by accepting their present oral condition. Alternatives to orthodontic treatment vary with the individual's specific problem, and prosthetic solutions or limited orthodontic treatment may be considerations. You are encouraged to discuss alternatives with the doctor prior to beginning treatment.

Orthodontics and Dentofacial Orthopedics is the dental specialty that includes the diagnosis, prevention, interception and correction of malocclusion, as well as neuromuscular and skeletal abnormalities of the developing or mature orofacial structures.

An orthodontist is a dental specialist who has completed at least two additional years of graduate training in orthodontics at an accredited program after graduation from dental school.



American Association of Orthodontists

Results of Treatment

Orthodontic treatment usually proceeds as planned, and we intend to do everything possible to achieve the best results for every patient. However, we cannot guarantee that you will be completely satisfied with your results, nor can all complications or consequences be anticipated. The success of treatment depends on your cooperation in keeping appointments, maintaining good oral hygiene, avoiding loose or broken appliances, and following the orthodontist's instructions carefully.

Length of Treatment

The length of treatment depends on a number of issues, including the severity of the problem, the patient's growth and the level of patient cooperation. The actual treatment time is usually close to the estimated treatment time, but treatment may be lengthened if, for example, unanticipated growth occurs, if there are habits affecting the dentofacial structures, if periodontal or other dental problems occur, or if patient cooperation is not adequate. Therefore, changes in the original treatment plan may become necessary. If treatment time is extended beyond the original estimate, additional fees may be assessed.

Discomfort

The mouth is very sensitive so you can expect an adjustment period and some discomfort due to the introduction of orthodontic appliances. Non-prescription pain medication can be used during this adjustment period.

Relapse

Completed orthodontic treatment does not guarantee perfectly straight teeth for the rest of your life. Retainers will be required to keep your teeth in their new positions as a result of your orthodontic treatment. You must wear your retainers as instructed or teeth may shift, in addition to other adverse effects. Regular retainer wear is often necessary for several years following orthodontic treatment. However, changes after that time can occur due to natural causes, including habits such as tongue thrusting, mouth breathing, and growth and maturation that continue throughout life. Later in life, most people will see their teeth shift. Minor irregularities, particularly in the lower front teeth, may have to be accepted. Some changes may require additional orthodontic treatment or, in some cases, surgery. Some situations may require non-removable retainers or other dental appliances made by your family dentist.

Extractions

Some cases will require the removal of deciduous (baby) teeth or permanent teeth. There are additional risks associated with the removal of teeth which you should discuss with your family dentist or oral surgeon prior to the procedure.

Orthognathic Surgery

Some patients have significant skeletal disharmonies which require orthodontic treatment in conjunction with orthognathic (dentofacial) surgery. There are additional risks associated with this surgery which you should discuss with your oral and/or maxillofacial

surgeon prior to beginning orthodontic treatment. Please be aware that orthodontic treatment prior to orthognathic surgery often only aligns the teeth within the individual dental arches. Therefore, patients discontinuing orthodontic treatment without completing the planned surgical procedures may have a malocclusion that is worse than when they began treatment!

Decalcification and Dental Caries

Excellent oral hygiene is essential during orthodontic treatment as are regular visits to your family dentist. Inadequate or improper hygiene could result in cavities, discolored teeth, periodontal disease and/or decalcification. These same problems can occur without orthodontic treatment, but the risk is greater to an individual wearing braces or other appliances. These problems may be aggravated if the patient has not had the benefit of fluoridated water or its substitute, or if the patient consumes sweetened beverages or foods.

Root Resorption

The roots of some patients' teeth become shorter (resorption) during orthodontic treatment. It is not known exactly what causes root resorption, nor is it possible to predict which patients will experience it. However, many patients have retained teeth throughout life with severely shortened roots. If resorption is detected during orthodontic treatment, your orthodontist may recommend a pause in treatment or the removal of the appliances prior to the completion of orthodontic treatment.

Nerve Damage

A tooth that has been traumatized by an accident or deep decay may have experienced damage to the nerve of the tooth. Orthodontic tooth movement may, in some cases, aggravate this condition. In some cases, root canal treatment may be necessary. In severe cases, the tooth or teeth may be lost.

Periodontal Disease

Periodontal (gum and bone) disease can develop or worsen during orthodontic treatment due to many factors, but most often due to the lack of adequate oral hygiene. You must have your general dentist, or if indicated, a periodontist monitor your periodontal health during orthodontic treatment every three to six months. If periodontal problems cannot be controlled, orthodontic treatment may have to be discontinued prior to completion.

Injury From Orthodontic Appliances

Activities or foods which could damage, loosen or dislodge orthodontic appliances need to be avoided. Loosened or damaged orthodontic appliances can be inhaled or swallowed or could cause other damage to the patient. You should inform your orthodontist of any unusual symptoms or of any loose or broken appliances as soon as they are noticed. Damage to the enamel of a tooth or to a restoration (crown, bonding, veneer, etc.) is possible when orthodontic appliances are removed. This problem may be more likely when esthetic (clear or tooth colored) appliances have been selected. If damage to a tooth or restoration occurs, restoration of the involved tooth/teeth by your dentist may be necessary.

Headgears

Orthodontic headgears can cause injury to the patient. Injuries can include damage to the face or eyes. In the event of injury or especially an eye injury, however minor, immediate medical help should be sought. Refrain from wearing headgear in situations where there may be a chance that it could be dislodged or pulled off. Sports activities and games should be avoided when wearing orthodontic headgear.

Temporomandibular (Jaw) Joint Dysfunction

Problems may occur in the jaw joints, i.e., temporomandibular joints (TMJ), causing pain, headaches or ear problems. Many factors can affect the health of the jaw joints, including past trauma (blows to the head or face), arthritis, hereditary tendency to jaw joint problems, excessive tooth grinding or clenching, poorly balanced bite, and many medical conditions. Jaw joint problems may occur with or without orthodontic treatment. Any jaw joint symptoms, including pain, jaw popping or difficulty opening or closing, should be promptly reported to the orthodontist. Treatment by other medical or dental specialists may be necessary.

Impacted, Ankylosed, Unerupted Teeth

Teeth may become impacted (trapped below the bone or gums), ankylosed (fused to the bone) or just fail to erupt. Oftentimes, these conditions occur for no apparent reason and generally cannot be anticipated. Treatment of these conditions depends on the particular circumstance and the overall importance of the involved tooth, and may require extraction, surgical exposure, surgical transplantation or prosthetic replacement.

Occlusal Adjustment

You can expect minimal imperfections in the way your teeth meet following the end of treatment. An occlusal equilibration procedure may be necessary, which is a grinding method used to fine-tune the occlusion. It may also be necessary to remove a small amount of enamel in between the teeth, thereby "flattening" surfaces in order to reduce the possibility of a relapse.

Non-Ideal Results

Due to the wide variation in the size and shape of the teeth, missing teeth, etc., achievement of an ideal result (for example, complete closure of a space) may not be possible. Restorative dental treatment, such as esthetic bonding, crowns or bridges or periodontal therapy, may be indicated. You are encouraged to ask your orthodontist and family dentist about adjunctive care.

Third Molars

As third molars (wisdom teeth) develop, your teeth may change alignment. Your dentist and/or orthodontist should monitor them in order to determine when and if the third molars need to be removed.

Continued on next page

Patient or Parent/Guardian Initials _____

Patient

Date _____

Occasionally, patients can be allergic to some of the component materials of their orthodontic appliances. This may require a change in treatment plan or discontinuance of treatment prior to completion. Although very uncommon, medical management of dental material allergies may be necessary.

General health problems such as bone, blood or endocrine disorders, and many prescription and non-prescription drugs (including bisphosphonates) can affect your orthodontic treatment. It is imperative that you inform your orthodontist of any changes in your general health status.

Smoking or chewing tobacco has been shown to increase the risk of gum disease and interferes with healing after oral surgery. Tobacco users are also more prone to oral cancer, gum recession, and delayed tooth movement during orthodontic treatment. If you use tobacco, you must carefully consider the possibility of a compromised orthodontic result.

Your treatment may include the use of a temporary anchorage device(s) (i.e. metal screw or plate attached to the bone.) There are specific risks associated with them.

It is possible that the tissue around the device could become inflamed or infected, or the soft tissue could grow over the device, which could also require its removal, surgical excision of the tissue and/or the use of antibiotics or antimicrobial rinses.

When inserting the device(s), it is possible to damage the root of a tooth, a nerve, or to perforate the maxillary sinus. Usually these problems are not significant; however, additional dental or medical treatment may be necessary.

If any of the complications mentioned above do occur, a referral may be necessary to your family dentist or another dental or medical specialist for further treatment. Fees for these services are not included in the cost for orthodontic treatment.

I hereby acknowledge that I have read and fully understand the treatment considerations and risks presented in this form. I also understand that there may be other problems that occur less frequently than those presented, and that actual results may differ from the anticipated results. I also acknowledge that I have discussed this form with the undersigned orthodontist(s) and have been given the opportunity to ask any questions. I have been asked to make a choice about my treatment. I hereby consent to the treatment proposed and authorize the orthodontist(s) indicated below to provide the treatment. I also authorize the orthodontist(s) to provide my health care information to my other health care providers. I understand that my treatment fee covers only treatment provided by the orthodontist(s), and that treatment provided by other dental or medical professionals is not included in the fee for my orthodontic treatment.

Witness _____ Date _____

I hereby consent to the making of diagnostic records, including x-rays, before, during and following orthodontic treatment, and to the above doctor(s) and, where appropriate, staff providing orthodontic treatment prescribed by the above doctor(s) for the above individual. I fully understand all of the risks associated with the treatment.

I hereby authorize the above doctor(s) to provide other health care providers with information regarding the above individual's orthodontic care as deemed appropriate. I understand that once released, the above doctor(s) and staff has(have) no responsibility for any further release by the individual receiving this information.

I hereby give my permission for the use of orthodontic records, including photographs, made in the process of examinations, treatment, and retention for purposes of professional consultations, research, education, or publication in professional journals.

Relationship to Patient

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There is a vertical margin line on the left side, creating a narrow left margin. The paper appears to be from a notebook or a standard writing template.

Patient or Parent/Guardian Initials _____

All About Smiles

Maria C. Mendez, DMD,MS

Acknowledgement of receipt of "Notice of Privacy Practices"

****You May Refuse to Sign This Acknowledgement****

I have received a copy of this office's Notice of Privacy Practices.

Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

© 2002 American Dental Association-All Rights Reserved

Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

Authorization for release of patient records and information

I hereby authorize All About Smiles to release any medical/financial records including information concerning my illness and/or treatment to the following:

Name

Address

City, State & Zip Code

Phone Number

Relationship

Name

Address

City, State & Zip Code

Phone Number

Relationship

Name

Address

City, State & Zip Code

Phone Number

Relationship

Name

Address

City, State & Zip Code

Phone Number

Relationship