

WELCOME

We would like to welcome you to our office. In an effort to provide the best service possible, we ask that you fill out this form as completely as possible. Thank you for your cooperation.

Confidential Patient Information - Adult

Patient's Name _____ Age _____ Birth Date _____
First Middle Last

Email _____ SS# _____

Home Phone _____ Cell Phone _____

Home Address _____ City, State, Zip _____

Mailing Address _____ How long? _____

Employer _____ Work # _____

Occupation _____ How long? _____

Marital Status: Single Married Widowed Divorced Separated Domestic Partner

Spouse's Name _____

Spouse's Employer _____ Work # _____

Occupation _____ How long? _____

General Dentist _____ How did you hear about our office? _____

Have we treated another member of your family? YES NO if YES, Name _____
First Middle Last

What are the main concerns that you would like orthodontics to accomplish? _____

Have you visited an orthodontist before? YES NO If YES, for what reason? _____

Dental Insurance Information Primary

Insurance Company Name _____ Insurance Company Phone _____

Insurance Company Address _____ Group or Plan _____

Insured's Name _____ Insured's Birthdate _____

Relationship _____ Insured's SS# _____

Insured's Employer _____ Employer's Address _____

Secondary

Insurance Company Name _____ Insurance Company Phone _____

Insurance Company Address _____ Group or Plan _____

Insured's Name _____ Insured's Birthdate _____

Relationship _____ Insured's SS# _____

Insured's Employer _____ Employer's Address _____

Emergency Information

Name of nearest relative/friend NOT LIVING WITH YOU _____ Relationship _____

Complete Address _____

Phone Number _____

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

Updates (Date/Initial) _____ Signature _____