WELCOME

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

Patient Information - Adult

Patient's Name _____ (First / Middle / Last) Age _____ Birth Date _____

Nickname (if preferred) _____ Male Female

Home Phone _____ Cell Phone _____ SS # _____

Home Address _____ (Street) City, State, ZIP _____

Employer _____ Employer's Address _____

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? _____

Anything you would like to discuss with the doctor in private? YES NO

Insurance Information

Marital Status Single Married Widowed Divorced Separated Domestic Partner

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 _____