WELCOME

Date_____

Patient's Name_____
Last Name First Name Middle Initial

I prefer to be called _____ ( ) Female ( ) Male

Age_____ Birth Date_____/_____/_____ Soc. Security #_____-_____-_____
Month Day Year

Home Address _____Email_____

City _____State _____Zip _____

Home Phone ( )_____Work Phone ( ) _____Cell Phone ( )_____

Your Regular Dentist_____

Employer_____Address_____

Dental/Orthodontic Insurance Yes / No Name of Company_____

Have other family members had an orthodontic evaluation or braces here? Yes / No Whom? _____

Thank You for coming. Did someone tell you about us or refer you? Yes / No Whom?_____

Spouse

Name _____Date of Birth _____/_____/_____ Soc. Security #_____-_____-_____
Month Day Year

Home Address_____
(If different from patient)

Home Phone ( )_____Work Phone ( ) _____Cell Phone ( )_____

Employer _____Address_____

Dental/Orthodontic Insurance Yes / No Name of Company _____

Additional Orthodontic Insurance

Name of Insurance Co._____Employer _____

Policyholder Name_____Address_____

Relationship to Patient_____Date of Birth _____/_____/_____ Soc. Security #_____-_____-_____
Month Day Year

Emergency Contact: _____Phone _____

I verify that the above information is true and correct. If applicable, I authorize this office to file to my Insurance Company(s) any information that facilitates the use of my insurance benefits. I understand that my insurance is a contract that I have between my employer and the insurance company and that I am responsible for all charges not paid by my insurance company.

_____ _____
Signature of Patient Date

I agree that pictures taken of me may be displayed in the office.

_____ _____
Signature of Patient Date