

WELCOME TO OUR OFFICE

So that we might become better acquainted, please complete both sides of this form.

ADULT PATIENT INFORMATION

Patient's Name _____ Prefer to be called _____ Sex _____
 Mailing Address _____ City _____ Zip _____
 Home Phone _____ Cell _____ Age _____ Birth date _____
 Email Address _____ May we contact you by email? Yes No
 Patient's Dentist _____ Phone Number _____
 Referred by _____ Do you know a patient currently in our practice? Whom _____
 Who noticed the orthodontic problem? Patient Dentist Other _____
 Describe the orthodontic problem in your own words _____
 What concerns you most about the thought of orthodontic treatment?
 appearance in appliances cost length of time discomfort results other _____
 Occupation _____ Employer _____ Work Phone _____

FAMILY AND ACCOUNT INFORMATION

Spouse's Name _____ Employer _____ Wk Phone _____

If other than self or spouse:

Person responsible for account _____ Relationship _____
 Address _____ City _____ Zip _____
 Home Phone _____ Work Phone _____ Cell Phone _____

INSURANCE INFORMATION

A dental insurance policy is a contract between the insured and the insurance company. Our professional services are rendered and charged directly to the patient's account and ***the patient or person responsible for the account is responsible for payment of all fees incurred.*** For your convenience, we will gladly assist you in submitting insurance claims pertaining to any charge for care in our office. If you wish assistance, we ask that you provide us with a claim form from your insurance carrier on your first visit or as soon as possible. Otherwise we will assume you are submitting all claims to your insurance carrier and the fees will be due in full from you at time of service or billing.

Primary Insurance

Name of insured (Employee) _____ SS# or ID# _____ DOB _____
 Insurance Co. _____ Group # _____ Ins. Phone # _____
 Employer _____

Secondary Insurance

Name of insured (Employee) _____ SS# or ID# _____ DOB _____
 Insurance Co. _____ Group # _____ Ins. Phone # _____
 Employer _____

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your dental care. All information will be kept completely confidential.

MEDICAL HISTORY

Physician's Name _____ Phone _____

