Please fill out this form completely, it is important to your dental care. Our goal is to help you reach and maintain good oral health.

Welcome to the Orthodontist

About You

Today's Date: _____

Name: _____ ☐ M ☐ F
Last First MI

Birthdate: ____/____/____ Age: _____ SS# : _____

Home Address: _____

_____
City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (_____)_____ Cell #: (_____)_____

Wk #: (_____)_____ DL #: _____

E-mail Address: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

How long there? _____ Occupation: _____

What time is best to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Dentist Name: _____

Previous or Present (Please Circle) Date of last visit? _____

Person Responsible for Account: _____

Spouse Information

His/Her Name: _____

Employer: _____

Wk #: (_____)_____ SS #: _____

Birthdate: ____/____/____ DL #: _____

Relative or friend not living with you.

Name: _____ Relation: _____

Wk #: (_____)_____ Hm #: (_____)_____

Orthodontic Insurance

PRIMARY

Orthodontic Coverage? ☐ Y ☐ N Dental Coverage? ☐ Y ☐ N

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: (_____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip

SECONDARY

Orthodontic Coverage? ☐ Y ☐ N Dental Coverage? ☐ Y ☐ N

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: (_____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip

Payment is due in full at the time of treatment unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and for paying any co-payment that my insurance does not cover, including the deductible. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____
SIGNATURE DATE

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