

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: \_\_\_\_\_

## 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

## Spouse Information

His/Her Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ SS #: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ DL #: \_\_\_\_\_

Relative or friend not living with you.

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

**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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