

Adult Orthodontic Form

Patient's Name: _____

Date: _____

Patient Information:

Address: _____
Date of Birth: _____ Sex (please circle): Male Female
Home Phone: _____ Cell Phone#: _____ Email: _____
Social Security #: _____
Patient's Employer: _____ Work Phone#: _____
Patient's Dentist: _____ Dentist Phone#: _____
Patient's Physician: _____ Physician Phone#: _____
Who may we thank for your referral? _____
Hobbies: _____
Marital status: Single Married Divorced Separated Widowed
Other family members seen by our office (name & age): _____

Billing Party Information:

Name: _____
First Last Middle Initial
Mailing Address: _____ City: _____ Zip: _____
How long at this address: _____
Previous Address (if less than 3 yrs.): _____
Home Phone: _____ Cell Phone#: _____ Email: _____
Social Security #: _____ Birth Date: _____ Relationship to Patient: _____
Employer: _____ Occupation: _____ # of Years Employed: _____
Spouse's Name: _____ Relationship to Patient: _____
Employer: _____ Occupation: _____ # Years Employed: _____
Social Security #: _____ Birth Date: _____ Daytime Phone#: _____

Insurance Information:

Insured's Name: _____ Insured's Soc. Sec. #: _____
Insurance Company: _____ Group #: _____ Local #: _____
Insured's Employer: _____ Insured's Birth Date: _____
Insurance Co. Address: _____
Insurance Co Phone #: _____
Do you have dual coverage? Yes No If yes, complete the following:
Insured's Name: _____ Insured's Soc. Sec. #: _____
Insurance Company: _____ Group #: _____ Local #: _____
Insured's Employer: _____ Insured's Birth Date: _____
Insurance Co. Address: _____

Contact Information:

I prefer to be contacted during the day by: Cell Phone #: _____
 Home Phone #: _____
 Email: _____

This office reserves the right to verify the credit status of potential patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services

Signature: _____ Date: _____

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

Signature: _____ Date: _____