Adult Patient Information

Name:_____
First Last "Preferred Name"

Street Address:_____

City:_____State:_____Zip:_____

Cell Phone:_____Work Phone:_____

Home Phone:_____Email Address:_____

Age:_____Date of Birth:_____Sex:_____

Dentist Name:_____Did dentist refer you to our office?_____

Insurance Information

Primary Insurance Co. Name:_____Orthodontic Coverage? Yes___No___

Insurance Co. Address:_____

Phone #:_____Group #:_____

Policy Owner's Name:_____Policy # or SS#:_____

Policy Owner's Birthdate:___/___/___Employer:_____Relationship to Patient:_____

Do you have Secondary insurance? Yes No ***If so, please provide the front desk with your insurance card.

Dental/Medical Information

I am interested in the following: *Traditional Braces

*Ceramic (clear) Brackets

*Lingual Brackets (Behind the Teeth)

*Invisalign

My Concerns:_____

Any medical conditions/medications/treatments we should be aware of?_____

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