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P (317) 888-7807 **F (317) 888-0083**

Welcome to our office! Please complete this form and bring it with you to your examination appointment.

Examination Date _______________/_____/______________________________
Day Date Time

Patient Information

Patient's Name ______________________________ Nickname_______________ Male _______ Female_________

Street______________________________________City____________________State___________Zip___________

Home Phone_______________________Cell.____________________Email__________________________________

Age: Yrs._________ Mos._________ Date of Birth__________/__/__________

School ____ Grade______________________________________

Special hobbies / interests ____

Patient resides with: ☐ Father ☐ Mother ☐ Both ☐ Other

Name of other family members treated in this office ____

Who may we thank for referring you to our office? ____________________ Family Dentist ___________________

Does patient have orthodontic insurance benefits? ☐ No ☐ Yes If yes, see other side of form.

Parent's Information

	Father	Mother
Name		
Address (if different from above)		
Home #		
SS#		
Employer's Name		
Business Address		
Business #		
Occupation		
Person Responsible for Account		

If other than parent

Name ___________________________________ Relationship ____________________ Home # _______________

Street ______________________________ City ____________________ State ___________ Zip ______________

Employer ____ Business # ___________________________________

Credit information will be verified for each account.

Emergency Information

Name ______________________________ Phone # _______________________ Relationship ________________

Name ______________________________ Phone # _______________________ Relationship ________________

Orthodontic Insurance

In order to assist you in receiving the maximum benefit from your orthodontic insurance, please complete the following information.

Primary
Insurance Co. ______________________________

Address ______________________________

City __________ State ______ Zip __________

Phone # ______________________________
(800 # if available)

Group ______________________________
(Plan, Local, Policy #)

Policy Owner's Name ____________________

Relationship to Patient ____________________

Employer ______________________________

Address ______________________________

Policy Owner's Birthdate ____________________

SS# ______________________________

Secondary
Insurance Co. ______________________________

Address ______________________________

City ______________ State ______ Zip ________

Phone # ______________________________
(800 # if available)

Group ______________________________
(Plan, Local, Policy #)

Policy Owner's Name ____________________

Relationship to Patient ____________________

Employer ______________________________

Address ______________________________

Policy Owner's Birthdate ____________________

SS# ______________________________

I authorize release of any information relating to this claim and need to have my signature on file for purposes of claim processing.

____
Signature

____
Date

For Office Use Only

Primary Eligibility _____ Yes _____ No

LTM ________ % ________

Deductible ____________________

Age Restrictions ________________

Cont of Tx ______ Yes ________ No

Monthly / Qtyly ________________

Available Benefit ________________

If patient is not eligible for orthodontic benefits, is there coverage for diagnostic procedures? ____ Yes ___ No

Date ____________ By _____________

Secondary Eligibility _______ Yes ________ No

LTM _________ % ________

Deductible ______________________

Age Restrictions ____________________

Cont of Tx _________Yes _________ No

Monthly / Qtyly ______________________

Available Benefit ____________________

If patient is not eligible for orthodontic benefits, is there coverage for diagnostic procedures? ___ Yes ___ No

Date _______________ By ____________