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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

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

Father	Mother

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. _____	Secondary Insurance Co. _____
Address _____	Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Phone # _____ (800 # if available)	Phone # _____ (800 # if available)
Group _____ (Plan, Local, Policy #)	Group _____ (Plan, Local, Policy #)
Policy Owner's Name _____	Policy Owner's Name _____
Relationship to Patient _____	Relationship to Patient _____
Employer _____	Employer _____
Address _____	Address _____
Policy Owner's Birthdate _____	Policy Owner's Birthdate _____
SS# _____	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	Secondary Eligibility _____ Yes _____ No
LTM _____ % _____	LTM _____ % _____
Deductible _____	Deductible _____
Age Restrictions _____	Age Restrictions _____
Cont of Tx _____ Yes _____ No	Cont of Tx _____ Yes _____ No
Monthly / Qtyly _____	Monthly / Qtyly _____
Available Benefit _____	Available Benefit _____
If patient is not eligible for orthodontic benefits, is there coverage for diagnostic procedures? ____ Yes ____ No	If patient is not eligible for orthodontic benefits, is there coverage for diagnostic procedures? ____ Yes ____ No
Date _____ By _____	Date _____ By _____