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Welcome to our office! We look forward to seeing you at your complimentary orthodontic consult. Please fill out this form completely in ink. If you have any questions, please feel free to ask—we'll be happy to help.

Date: ________________

Patient Information

Patient's name: ______________________________ **Date of birth:** __________ **Age:** ______ **Sex: M F**

Address: ____
(street) (city) (state) (zip)

Home Phone: ________________ **Cell Phone:** ________________ **Work:** ________________

Email Address: ______________________________ **Referred by:** __________________________

If patient is a child

Grade: ______ **School:** ________________________

Responsible Party Information

Name: ____

Address: ______________________________________

City: __________________________ Zip: ____________

Years at this address: _____ If less than 3 years, previous

address: ______________________________________

Home Phone: ____________ Cell Phone: ____________

Work Phone: ____________ Email: ________________

Employer: _____________________________________

Job Title: ______________________ # Years: ________

Responsible Party Information

Name: ____

Address: ______________________________________

City: __________________________ Zip: ____________

Years at this address: _____ If less than 3 years, previous

address: ______________________________________

Home Phone: ____________ Cell Phone: ____________

Work Phone: ____________ Email: ________________

Employer: _____________________________________

Job Title: ______________________ # Years: ________

Family Information

With whom does the patient live: ____________________

Other adults we should know about:

Name: ____________________ Relationship: __________

Home: __________ Cell: __________ Work: __________

Name: ____________________ Relationship: __________

Home: __________ Cell: __________ Work: __________

Names of family or friends seen in our office:

____

____

____

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____

Dental Insurance Information

Policy Holders Name: ____________________________

Social Security: ____________ ID: ________________

Group: _______________ Birthdate: _______________

Employer: _____________ Insurance Co.: ____________

Insurance Address: ______________________________

_______________ Phone: _________________________

Secondary Insurance

Policy Holders Name: ____________________________

Social Security: ____________ ID: ________________

Group: _______________ Birthdate: _______________

Employer: _____________ Insurance Co.: ____________

Insurance Address: ______________________________

_______________ Phone: _________________________

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