

The benefits of a happy, healthy smile are immeasurable!
 Our goal is to help you reach and maintain optimal oral health.
 Please fill out this form completely. The better we communicate,
 the better we can care for you.

About You

Today's Date: _____

E-mail Address: _____

Name: _____
Last First Mi Mr Mrs Ms Dr

I prefer to be called: _____ Male Female

Birthdate: ____/____/____ Age: ____ SS#: _____

Home Address: _____
Apt/Condo #

City State Zip
 Single Married Divorced Widowed Separated

Hm #: (____) _____ Cell / Other #: _____

Wk #: (____) _____ Ext: ____ DL #: _____

Employer: _____

Employer's Address: _____

City State Zip

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Person Responsible for Account: _____

Orthodontic Insurance

Primary

Orthodontic Coverage? Yes No Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

City State Zip

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's SS #: _____

Insured's Employer: _____

Employer's Address: _____

City State Zip

Secondary

Orthodontic Coverage? Yes No Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

City State Zip

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's SS #: _____

Insured's Employer: _____

Employer's Address: _____

City State Zip

Spouse Information

His / Her Name: _____

Employer: _____

Wk #: (____) _____ Ext: ____ SS #: _____

Birthdate: ____/____/____ DL #: _____

Relative or Friend not living with you.

His / Her Name: _____ Relation: _____

Wk #: (____) _____ Hm #: (____) _____

Payment is due in full at the time of treatment
 unless prior arrangements have been approved.

If this office accepts insurance, 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. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature _____

Date _____

