Adult Patient Information (Please Print)

Name: ________________________ Date Of Birth: ________________ Age: ________

Home Address: ____

City State Zip Code

Home Phone: ( )_________________________ Cell Phone: ( )_______________

Employed By:____

Job Title:______________________________ Employer's Phone: ( )_______________

Employer's Address:____

City State Zip Code

Social Security #:__________________________ Marital Status:___________________

Email Address:____

Spouse's Name:____

Spouse's Employer:____

Spouse's Job Title:____

Spouse's Employer's Phone: ( )____

Spouse's Employer's Address:____

City State Zip Code

Who referred you to us?____

Medical History

Please Check	Yes	No
1. Are you in good health?	☐	☐
2. Do you have regular medical examinations?	☐	☐
3. Do you have any history of heart trouble, allergies, diabetes, asthma, hepatitis, kidney, or liver involvement, epilepsy, or bleeding disorders?	☐	☐
4. Do you have a cerebral or spastic condition or mental imbalance?	☐	☐
5. Have you ever experienced any unfavorable reaction to medicine, Such as: penicillin, aspirin, or novocaine? (Please specify in line 10)	☐	☐
6. Are you taking any drugs or medication regularly? (Specify in line 10)	☐	☐

7. Who is your Medical Doctor? ________________________ Phone: _________________
8. Who is your Dentist? ________________________________ Phone: _________________
9. Have you ever had orthodontic treatment in the past? ____________________________
10. Is there anything we should know about you that would adversely affect orthodontic treatment?

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Signature: ____ Date: ___________________

For Dental Insurance Only

Primary Insurance

Dental Coverage ☐ Yes ☐ No Orthodontic Coverage ☐ Yes ☐ No

Insurance Co. Name: ____________________________ Phone: (   ) __________
Group # (Plan, Local, or Policy #): _______________________________________
Policy Owner's Name: ___________________________ Relationship: __________
Policy Owner's Date of Birth: ___________ / _______ / _____________________
Social Security # or Subscriber ID #: _____________________________________
Policy Owner's Employer's Name: _______________________________________

Secondary Insurance

Dental Coverage ☐ Yes ☐ No Orthodontic Coverage ☐ Yes ☐ No

Insurance Co. Name: ____________________________ Phone: (   ) __________
Group # (Plan, Local, or Policy #): _______________________________________
Policy Owner's Name: ___________________________ Relationship: __________
Policy Owner's Date of Birth: ___________ / _______ / _____________________
Social Security # or Subscriber ID #: _____________________________________
Policy Owner's Employer's Name: _______________________________________

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverages. Signture provides authorization for credit bureau check.

Signature: ____ Date: _____________