Welcome

Welcome to our office. It will be great pleasure to serve and help you with your orthodontic treatment needs. Please fill the following information.

Information

Patient Information – Please Print

* Required Field

Patient's Name*			Date*	
Street Address*		City*	State*	Zip Code*
Social Security Number	Birth date*	Male/Female*	Student Status ☐ Full Time ☐ Part Time	
Home Phone*	Work Phone	Cell Phone	Email Address	

Parent / Legal Guardian's Information (Required if patient is minor)

Name*			Relationship to patient*	
Street Address ☐ Same as above		City	State	Zip Code
Home Phone*	Work Phone	Cell Phone	Email Address	

Other Information

School Name	Grade	Hobbies/Sports/Interests
Other Family Members Seen By Us	How did you find us?	
Who may we thank for referring you to our office?	Why did you choose us?	

Emergency Contact Information

Name of Nearest Relative NOT Living with You*	Relationship
Address	Phone*

Dental History

General Dentist's Name*			Dental office phone no.*	
Street Address		City	State	Zip Code
Date of last teeth cleaning?*	Any pending dental work?* ☐ No ☐ Yes , List:			

Do you have any orthodontic insurance coverage? ☐ No ☐ Yes

If yes, please fill the Insurance information form.

Thank you for selecting our office to serve you.