

ADULT PATIENT INFORMATION SHEET

PLEASE PRINT CLEARLY AND FILL OUT BOTH SIDES OF FORM COMPLETELY

Today's Date ___/___/___

Patient's Name: _____

Preferred Name: _____

Address: _____

City: _____

State/Zip: _____ / _____

Home Phone: (____) _____

Cell Phone: (____) _____

EMAIL ADDRESS: _____

Work Phone: (____) _____

Occupation: _____

Date of Birth: ___/___/___

Social Security#: _____

Current age: _____ M or F

Referred by: _____

CONTACT INFORMATION

Emergency Contact: _____

Phone#: _____

Cell Phone#: _____

Relation: _____

Marital Status: Married Single
Divorced Separated Widowed

Please circle one of the above

Dentist: _____

Dentist Address: _____

Dentist Phone#(____) _____

Physician: _____

Physician Address: _____

Physician Phone# (____) _____

COPY OF CURRENT VALID

DRIVER'S LICENSE REQUIRED

ORTHODONTIC INSURANCE ONLY

NOT MEDICAL INSURANCE

NOT DENTAL INSURANCE

Do you have Orthodontic insurance? Y or N

Name of Orthodontic Insurance Company**

Address: _____

Phone#: (____) _____

ID#: _____

Group #: _____

SUBSCRIBER INFORMATION

Subscriber's name: _____

Subscribers Date of Birth: ___/___/___

Subscriber's Social Security#: _____

Employed by: _____

Address: _____

Occupation: _____

Work Phone#: _____

Insurance through- Self Father Mother Other

Please circle one

*if other explain: _____

Subscriber's Name, Address, & Phone #'s

* Only if differs from patient's in any way

(Phone) _____

(Cell Phone) _____

**Only if there is a secondary ORTHODONTIC insurance, then see Billing Representative

Signature of responsible party

Print name of responsible party