



Discover your best smile

Welcome to our practice! Our goal is to ensure that our patients and their families receive the best possible orthodontic care and service. Please provide the following information about yourself.

Patient Information

Patient's Full Name: _____

Address: _____

Phone: _____

Birth Date: _____

School: _____

Whom should we thank for referring you to our office? _____

Have any of your friends or family members been treated in our office? _____

Phone or email address you prefer we use for appointment reminders: _____

If patient is a minor, please provide responsible party information below.

Name: _____

Relation to patient: _____

Address (if different from patient): _____

Phone (if different from patient): _____

Employer: _____

Employer Address: _____

Dental/Orthodontic Insurance Information:

(If you have your insurance card with you, please present it to the front desk)

PRIMARY COVERAGE

SECONDARY COVERAGE

Insurance Co: _____

Insurance Co: _____

Phone: _____

Phone: _____

Subscriber Name: _____

Subscriber Name: _____

Group #: _____

Group #: _____

Subscriber #: _____

Subscriber #: _____

Subscriber Date of Birth: _____

Subscriber Date of Birth: _____