ADULT PATIENT REGISTRATION

PATIENT INFORMATION

Today's Date _____

Legal Name Last _____ First _____ Middle _____

Preferred Name (If different) _____ Birthdate _____ Age _____

Phone Number [H] _____ [W] _____ [C] _____

E-mail _____ Gender _____

Address _____

City _____ State _____ Zip _____ Social Security # _____

Contact Method(s) ☐Home Phone ☐Cell ☐Work ☐E-mail ☐Text Message Cell Carrier _____

Dentist _____

Other family members who are patients with us _____

Whom may we thank for referring you?

☐Dentist or Doctor ☐Patient of Our Office ☐ Other Name of Referrer _____

☐I am financially responsible for my treatment

Emergency Contact Name _____

Relationship to Patient _____ Phone _____

FINANCIALLY RESPONSIBLE (If different than patient)

Name _____ Relationship to Patient _____

Phone Number [H] _____ [W] _____ [C] _____

E-mail _____ Birthdate _____

Address _____

City _____ State _____ Zip _____ Social Security # _____

Contact Method(s) ☐Home Phone ☐Cell ☐Work ☐E-mail ☐Text Message Cell Carrier _____

PRIMARY ORTHODONTIC INSURANCE

Name of Insurance _____ Insurance Phone # _____ Group # _____

Name of Subscriber _____ Subscriber's Ins. ID # _____

Subscriber's DOB _____ Relationship of Subscriber to Patient _____

Subscriber's Employer _____ Occupation _____

If the patient is not the subscriber please fill out the following information for the subscriber:

Address _____ City _____ State _____ Zip _____

Phone Number _____ Social Security # _____

SECONDARY ORTHODONTIC INSURANCE

Name of Insurance _____ Insurance Phone # _____ Group # _____

Name of Subscriber _____ Subscriber's Ins. ID # _____

Subscriber's DOB _____ Relationship of Subscriber to Patient _____

Subscriber's Employer _____ Occupation _____

If the patient is not the subscriber please fill out the following information for the subscriber:

Address _____ City _____ State _____ Zip _____

Phone Number _____ Social Security # _____