



# Welcome!

Date \_\_\_\_\_

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we will be glad to help you. We look forward to working with your child. During the examination, we may be talking to your dental insurance company to determine your orthodontic benefit.

## PATIENT INFORMATION

Patient's Name \_\_\_\_\_ (\_\_\_\_\_) Birthdate \_\_\_\_\_ Sex  M  F  
LAST FIRST MI PREFERRED NAME AGE

Address \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_  
STREET CITY STATE ZIP

If Patient is a minor, name of person(s) with Patient at exam \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Have we previously treated any other family member?  YES  NO If yes, whom? \_\_\_\_\_

What is expected from orthodontic treatment? \_\_\_\_\_

Patient's attitude toward braces:  Good  Bad  Indifferent

Whom may we thank for this referral? \_\_\_\_\_

How did you learn of our orthodontic office?  Insurance  Family Member  Sign/Location  Newspaper  Yellow Pages  local  Mpls/St. Paul  
 Dentist  Radio  Website  Friend Neighbor \_\_\_\_\_

## ACCOUNT INFORMATION

### If Patient is a Minor:

Custodial Parent/Legal Guardian \_\_\_\_\_

Address \_\_\_\_\_  
STREET CITY STATE ZIP

Do you rent or own?  Rent  Own How long have you been at this address? \_\_\_\_\_ Marital Status \_\_\_\_\_

Father's Daytime Phone/Cell \_\_\_\_\_ Employer \_\_\_\_\_

Mother's Daytime Phone/Cell \_\_\_\_\_ Employer \_\_\_\_\_

E-Mail address \_\_\_\_\_

Is Patient covered by orthodontic insurance?  YES  NO If yes, name of plan \_\_\_\_\_

### If Patient is an Adult:

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Daytime Phone/Cell \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Is Patient covered by orthodontic insurance?  YES  NO If yes, name of plan \_\_\_\_\_

## INSURANCE

Name of Dental Insurance Company \_\_\_\_\_

Claims Submission Address \_\_\_\_\_  
STREET CITY STATE ZIP

Name of Subscriber \_\_\_\_\_ Subscriber's Date of Birth \_\_\_\_\_

ID# or Social Security # \_\_\_\_\_ Insurance company phone number \_\_\_\_\_

## EMERGENCY CONTACT (person not living with Patient)

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone \_\_\_\_\_