

NEW PATIENT INFORMATION

Name _____ Date _____

Birth date _____ Age _____ Home phone _____

Nickname, or prefer to be called _____ Email _____

School _____ Grade level _____

Home Address _____
Street or Box No. City State Zip

Father's Full Name _____ Occupation _____

Work Phone _____ Cell _____ Social Security # _____

Home Address (if different) _____
Street or Box No. City State Zip

Business Address _____
Street or Box No. City State Zip

Mother's Full Name _____ Occupation _____

Work Phone _____ Cell _____ Social Security # _____

Home Address (if different) _____
Street or Box No. City State Zip

Business Address _____
Street or Box No. City State Zip

Insurance Co. _____ Subscriber _____ Policy # _____

Insurance Co. Address _____ Phone _____

Family Dentist _____ City _____

Whom may we thank for referring you? _____

Has patient previously seen another orthodontist? _____

Orthodontist's Name _____ City _____

List any previous orthodontic treatments _____

Has anyone else in your family been treated in our office? _____

Has the patient been a thumb-sucker? _____ Is the patient a mouth-breather? _____

List your primary orthodontic concerns _____

