Adult Orthodontic Acquaintance

Patient Information

Date _____

Patient's Name _____ Preferred Name _____

Address _____ City/Zip _____

Birthdate _____ Age _____ Gender: Male Female Dentist _____

Whom may we thank for recommending our office to you? _____

What do you think is your orthodontic problem? _____

What do you hope orthodontics will accomplish? _____

Responsible Party Information

Marital Status: ___ Married ___ Separated ___ Divorced ___ Widowed ___ Single

Person responsible for account (if other than above patient) _____

Address _____ City/Zip _____

No. years at this address _____ Previous address (if less than 3 years) _____

Home phone _____ Work phone _____ Relationship to patient _____

Social Security # _____ Birthdate _____

Employer _____ Occupation _____ No. years employed _____

If married:

Spouse's name _____

Spouse's employer _____ No. years employed _____

Occupation _____ SSN _____ Work phone _____

Are you covered by orthodontic insurance? _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____ Phone _____

(Over Please)