ADULT ORTHODONTIC AOUAINTANCE FORM

PATIENT SS#: _____ **TODAY'S DATE:** _____

PATIENT NAME: _____ **BIRTH DATE:** _____

ADDRESS: _____

_____

PHONES: Home: (____) _____ **Cell: (____)** _____ **Work: (____)** _____

PATIENT EMPLOYER: _____

EMPLOYER ADDRESS: _____

FAMILY MEMBERS: _____

INSURANCE INFO: Insured's Birthdate: _____ **Insured's SS#:** _____

INSURED'S NAME: _____ **Cell #:** _____

EMPLOYER NAME: _____ **Work Phone:** _____

EMPLOYER ADDRESS: _____

_____

DENTAL INSURANCE NAME: _____**INS. STATE**_____

INSURANCE ADDRESS: _____

GROUP ID#: _____ **EMPLOYEE ID#** _____

INS. PHONE: _____ **ORTHODONTIC COVERAGE: Yes No Unsure**

DENTIST'S NAME: _____ **OFFICE NAME:** _____

DENTAL OFFICE ADDRESS: _____

_____ **___OFFICE PHONE:**_____

REFERRED BY: _____

We are updating our appointment confirmation system and will need the following information:

FOR APPOINTMENT VERIFICATION: I, _____, authorize the practice to confirm orthodontic appointments via: (Select one).

Home Phone: _____ **E-mail (Address):** _____

Cell Phone: _____ **Text to:** _____

Signature of Parent/Guardian: _____