

Orthodontic Acquaintance Card - Adult

Patient Name _____ Name patient goes by _____

Date of birth _____ Age _____ M or F _____

Home Address _____ Apt. _____

City _____ State _____ Zip _____

Home phone (____) _____ Email address: _____

Occupation _____ Daytime phone (____) _____

Referred by _____ Have you seen another orthodontist? Y N

Your dentist _____ Your physician _____

Insurance Information:

Person or persons responsible for account _____

Home Phone (____) _____

Address if different from patient _____

City _____ State _____ Zip _____

Dental Insurance Carrier _____

Does your insurer provide orthodontic coverage? Y N unsure

Subscribers Name _____

Insurance ID # _____ Social Security # _____

Insurance Group # _____

Subscribers DOB _____

Employer _____

Employer Address _____

City _____ State _____ Zip _____

Have we seen any other members of your family?

Name: _____

What is the patient's attitude toward receiving orthodontic treatment? _____
