Orthodontics
Adult Patient Information

Welcome!

Thank you for selecting our office for your orthodontic evaluation. Please help us by completing this orthodontic health questionnaire. If you have any questions or need assistance, please ask us. We will be happy to help you.

Patient Information (confidential)

Patient's Name **Date** _____

_____

Last First Middle Initial Nickname

Age _____ Date of Birth _____ Sex _____

Address

Street _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____ E-mail _____

Marital Status: ○ Married ○ Separated ○ Divorced ○ Single

If married, spouse's name _____ Employer _____ Work Phone _____

How did you hear about our office? If referred by current patient, please provide their name so we can thank them!

○ Self ○ Dentist ○ Insurance Company ○ Internet Search ○ Referred by _____

Responsible Party

○ Self ○ Other — If other than self, please complete the following:

Name _____ Home Phone _____ Cell _____

Address _____ City _____ State _____ Zip _____

Employer _____ Work Phone _____

E-mail _____ Social Security # _____

Insurance Information

If you have orthodontic insurance, please complete the following (the person's information the insurance is under):

Name of the Insured _____ S.S. # _____ Date of Birth _____

Name of Insurance Company _____ Group # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Ins. Co. Phone No. _____

Concerns

When did you first realize that you might have a problem requiring orthodontic treatment?

_____

What concerns you most about your teeth or jaws? _____

_____

Which of the following best describes your interest in orthodontic treatment?

○ I want treatment. ○ I am willing if treatment is necessary. ○ I am not sure.