First Orthodontist visit

Date: _______________

Patient Name: __________________________________ Age/yrs. ______ with how many months_______

DOB: _____/______/___________

Parent Name or Legal guardian _______________________________________ Phone # _____-______-_________

Relation with patient: _______________________________ **Referred By**:__________________________________

Address___________________________________Apt #___________ City_______________ Zip code_____________

Dental Insurance: Yes ____ No____ Type of Insurance: __________________________

If your insurance doesn't cover the treatment, would you be interested in an in house payment plan? Y__ N___

Name of your Dentist:___________________________________ Phone # _____/______/________

Is this your first visit to an orthodontist: ______ , If NO when was your last visit:____/_____/_________

Describe briefly your dental problem or concerns:____

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Orthodontist Comments:

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