GENERAL INFORMATION

What concerns you about your teeth? ______________________________

Who suggested that you might need orthodontic treatment? ______________________________

Why did you select our office? ______________________________

Have you had any previous orthodontic treatment? Please describe ______________________________

Have any other family members been treated in this office? Please name them. ______________________________

Do you think that any of your work or leisure activities affect your teeth or jaws? Please explain. ______________________________

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? ______________________________

Address (*if different from page 1*) ______________________________ City, State, Zip ______________________________

Cell phone ______________________________ Home phone ______________________________

E-mail address(es) ______________________________

Social Security # ______________________________ Employer ______________________________

DENTAL INSURANCE

Primary policy holder's full name ______________________________ Birthdate ______________________________

Social Security # ______________________________ Relationship to patient ______________________________

Address and phone (if not listed above) ______________________________

Employer ______________________________ Address ______________________________

Insurance company ______________________________ Group # ______________________________ ID # ______________________________

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't know

Secondary policy holder's full name ______________________________ Birthdate ______________________________

Social Security # ______________________________ Relationship to patient ______________________________

Address and phone (if not listed above) ______________________________

Employer ______________________________ Address ______________________________

Insurance company ______________________________ Group # ______________________________ ID # ______________________________

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't know

MEDICAL INSURANCE

Policy holder's full name ______________________________

Insurance company ______________________________

©2022 American Association of Orthodontist
Revised 202