

WRIGHT ORTHODONTICS

WELCOME TO OUR OFFICE

{DR. WRIGHT'S ADULT PATIENT INFORMATION FORM}

Patient Name _____ Date _____

Social Security Number ___-___-____ Home Phone _____ Cell Phone _____

Age _____ Date of Birth _____ Female ___ Male ___

Spouse's Name _____

Home Address _____ City _____ State _____ Zip _____

Employer _____ Work Phone _____

Denitst _____ Date of last dental check-up _____

Emergency contact not living with you _____ Phone _____

Has any member of your family ever been treated at our office? _____

Whom may we thank for referring you to our office? _____

What are you favorite hobbies? _____

Is there Orthodontic Insurance? _____ Policy # _____

Primary Insurance Company Name _____

Address _____

Phone # _____

Name of Insured _____ Date of Birth _____

Secondary Insurance Company Name _____

Address _____ Policy # _____

Phone # _____

Name of Insured _____ Date of Birth _____

This office reserves the right to verify the credit status of potential patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of a credit reporting service.

Signature of Patient

Date