

ALIGN ORTHODONTICS & TMJ TREATMENT CENTER

Creating healthy, beautiful & confident smiles

PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide orthodontic services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: _____ Date of birth: _____ Sex: __ Age: _____
Home address: _____ City: _____ State: _____ Zip: _____
Billing address (if different): _____ City: _____ State: _____ Zip: _____
Home phone #: _____ Cell #: _____ E-mail: _____
Driver's license #: _____ State: _____ SS #: _____
Employer & Occupation: _____ Bus. Phone: _____
Spouse name & phone #: _____
Emergency contact name (not living with you): _____ Phone #: _____
Name of medical doctor: _____ Phone #: _____
Date of last visit to medical doctor: _____
Name of dentist: _____ Phone #: _____
Date of last visit to dentist: _____
Invited to our practice by: _____

PARENT/GAURDIAN INFORMATION

Name of parent/guardian: _____ Date of birth: _____ Sex: _____
SSN #: _____ Driver's license #: _____ State: _____
Employer & Occupation: _____ Bus. Phone: _____
Spouse name & phone #: _____
Spouse's employer name & phone #: _____

INSURANCE INFORMATION

Primary dental insurance: _____ Phone #: _____
Group #: _____ Employer & phone #: _____
Subscriber's name: _____ Date of birth: _____ Phone#: _____
SSN: _____ ID #: _____
Secondary dental insurance: _____ Phone #: _____
Group #: _____ Employer & phone #: _____
Subscriber's name: _____ Date of birth: _____ Phone#: _____
SSN: _____ ID #: _____