



ORTHODONTICS

For Children & Adults

John A. Freeman D.D.S., M.S.D.

Welcome to our practice . . . please tell us about yourself!

Today's Date: _____

PATIENT'S NAME (LAST, FIRST, INITIAL)		PREFERRED FIRST NAME	BIRTHDATE	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
STREET ADDRESS		CITY	ZIP	HOME PHONE NO.
IN CASE OF EMERGENCY, NOTIFY (NAME)		PHONE	RELATIONSHIP TO PATIENT	HOBBIES & SPORTS (optional)
WHO MAY WE THANK FOR REFERRING YOU? <input type="checkbox"/> DENTIST <input type="checkbox"/> FAMILY MEMBER <input type="checkbox"/> FRIEND <input type="checkbox"/> SIGN <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> OTHER (DESCRIBE):				
DENTIST'S NAME		WHEN LAST VISITED (approximate)	PHYSICIAN'S NAME	WHEN LAST VISITED (approximate)
FREQUENCY OF DENTAL CHECKUPS <input type="checkbox"/> TWICE A YEAR <input type="checkbox"/> ONCE A YEAR <input type="checkbox"/> ONLY IF THERE'S A PROBLEM <input type="checkbox"/> NEVER				FREQUENCY OF FLOSSING EACH WEEK?

Office Notes:

- PLEASE COMPLETE THE SECTION BELOW.
- THE SECTION AT THE RIGHT IS FOR A SPOUSE OR OTHER PERSON WHO IS FINANCIALLY RESPONSIBLE FOR THE PATIENT'S ACCOUNT

WORK INFORMATION	
May we call you at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	WORK PHONE NO. EXTENSION
OCCUPATION	EMPLOYER
WORK ADDRESS	
CITY	STATE ZIP
HOW LONG HAVE YOU WORKED THERE?	
DENTAL INSURANCE INFORMATION	
ORTHODONTIC INSURANCE? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> ???	SOCIAL SECURITY NO.
INSURANCE CO. NAME	GROUP NO. (IF KNOWN)
INSURANCE CO. STREET ADDRESS	
CITY	STATE ZIP
INSURANCE CO. PHONE NO.	

SPOUSE OR OTHER SECOND RESPONSIBLE PARTY	
NAME (LAST, FIRST, INITIAL)	
STREET ADDRESS (IF DIFFERENT FROM PATIENT'S)	
CITY	STATE ZIP
HOME PHONE NO. (IF DIFFERENT)	WORK PHONE NO.
OCCUPATION	EMPLOYER
WORK ADDRESS	
CITY	STATE ZIP
RELATIONSHIP TO PATIENT (SPOUSE, PARENT, ETC.)	
DENTAL INSURANCE INFORMATION	
BIRTHDATE OF RESPONSIBLE PARTY	SOCIAL SECURITY NO.
INSURANCE CO. NAME	GROUP NO. (IF KNOWN)
INSURANCE CO. STREET ADDRESS	
CITY	STATE ZIP
INSURANCE CO. PHONE NO.	

May we bill insurance for you? Yes No
Signature: _____

May we bill insurance for you? Yes No
Signature: _____

For Office Use Only	
ORTHO INS? <input type="checkbox"/> YES <input type="checkbox"/> NO	RECORDS SEP? <input type="checkbox"/> YES <input type="checkbox"/> NO
ORTHO MAX:	% PAID:
DEDUCTABLE:	BILL @:
NOTES:	

For Office Use Only	
ORTHO INS? <input type="checkbox"/> YES <input type="checkbox"/> NO	RECORDS SEP? <input type="checkbox"/> YES <input type="checkbox"/> NO
ORTHO MAX:	% PAID:
DEDUCTABLE:	BILL @:
NOTES:	

