NP LTR SENT: / / A B C	DATE : / / COMPLETED BY:
GP CALLED: / /	APT SCH: / / APT TIME: am pm
LAST CLEANING: / / PANOREX:	Confirmed: / / Spoke To:

Person who will be bringing patient to appointment:	ATTITUDE: Pleasant_____ Shy _____ Scared _____ Nervous _____ Angry _____ English is a second language_______________ Other:
Would you please spell your (child's) first / last name?	FIRST NAME: LAST NAME: PREFERS TO BE CALLED:
(When appropriate) Do you have a preference as to Orthodontist / office?	DR: OFFICE:
What is your (child's) date of birth?	DOB: (AGE:) GENDER F M
For your convenience, we will be sending a package of information which will include: a comprehensive health history, an office brochure and some miscellaneous forms. What is your **mailing address**?	HOME: CITY STATE ZIP SECONDARY ADDRESS: CITY STATE ZIP
Could I get your home phone number?	PHONE:
Have we had the opportunity to serve your friends or family?	
Who is the family dentist? Did Dr. ______ mention our office or did you hear about us from a friend?	DENTIST: DR. REFERRER:
What are his/her **orthodontic concerns**? Do you have **any other concerns?**	DDS CONCERN: PATIENT CONCERN:
For Child: When I mail the information to you, would you like me to address it to Mr. And Mrs.? What is your (husband's/wife's) first name?	FATHER'S NAME (if minor): MOTHER'S NAME (if minor):
Are there work or cell phone numbers that we can include in the account information?	WORK (if minor- Mom Dad Other:): CELL (if minor- Mom Dad Other:):
Is this the first visit to an Orthodontic office for (Patient's Name)?	First Visit ☐ Second Opinion ☐ Transfer ☐ Comments:
IS THERE ANYONE ELSE IN THE FAMILY YOU WOULD LIKE TO HAVE SEEN AT THIS TIME? (Explain Family Care Program)	NAME: DOB: / / AGE: APT.: / / TIME: am pm

What to expect: ELEVEN YRS OLD AND OVER: One of our Treatment Coordinators will acquaint you with our office and take digital photographs and an x-ray if needed. Dr. will examine (Patient's name) and use the photographs to discuss any orthodontic concerns. Please plan on being at the office approximately 60 minutes. TEN YRS OLD AND UNDER: Please plan on being at the office approximately 30 minutes for the exam. If Dr decides (Patient's Name) is ready to begin treatment at this time, for your convenience we have set aside time for the next step which is diagnostic records. Would you like us to hold that appointment for you? **YES NO**

TRANSFER: What is the name of your **previous orthodontist? Address and phone?**	DR. ADDRESS: PHONE:
INSURANCE: We have found that clarifying orthodontic benefits prior to the initial evaluation can be very helpful to our patients will allow us to factor that information into any payment options discussed. Are there possible orthodontic benefits that you would like us to verify?	EMPLOYEE'S NAME: DOB: SS#/ID# EMPLOYER: INS. PHONE:

Do you have any other questions that I haven't answered? Again, my name is . I am really looking forward to meeting both you and __ on ___ at ___. When you first walk in you will see that we have a computer that patients use to sign in but please stop at the front desk for this first visit so I can say hi. If you prefer, You can fill out your registration information at our website which is ______. You may also want to (have ___) visit our website prior to your visit. It's a great way to get to know us before you even come in!

Date Called: / / Spoke To: Mail Claims To:	EFFECTIVE DATE: / / WAITING PERIOD: MET: Yes No LIFETIME ORTHO MAX $____________ PAID AT ______% AGE LIMITATIONS? YES NO	BENEFITS USED? REMAINING BENEFITS? SUBMIT: ☐ Initial Only ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually CK SENT: ☐ In Full at Start ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually