ADULT EXAMINATION CARD

Patient's Name: Last _____ First _____ Middle _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Age _____ Birth Date _____ Sex _____

Hobbies _____ Musical Instrument _____

Occupation _____ Name of Employer _____

Work Phone Number _____ S.S.N. _____

Name of Spouse _____ S.S.N. _____

Birth Date _____

Occupation _____ Name of Employer _____

Patient's Dentist _____ Patient's Physician _____

Referred By _____

Insurance Coverage for Orthodontic Treatment? Yes_____ No_____

Primary Insurance Information	Secondary Insurance Information
Policyholder Name _____	_____
ID/SS# _____	_____
Group # _____	_____
Insurance Name _____	_____
Insurance Address _____	_____
_____	_____
Insurance Phone # _____	_____

I understand that I am financially responsible for all charges incurred.
Signature of Responsible Party _____