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Tell us about Yourself

1. Name _____
Last First Middle Preferred Name
 Male Female Birth Date: _____ Age: _____
 Address: _____ How long at this address: _____
 Home Phone: (____) _____ E-Mail: _____
 Family in treatment with us: _____
 Whom may we thank for referring you? _____
 Dentist: _____ Last visit Date: _____

2. Employer Information
 Employer: _____ Job Title: _____
 Work Phone #: (____) _____ Cell phone #: (____) _____
 How long at current job: _____ S.S. #: _____

3. Marital Status Single Married Widowed Divorced Separated

4. Spouse Information
 Name: _____ Birth Date: _____
 Employer: _____ Work Phone #: (____) _____
 How long at current job: _____ S.S. #: _____

5. Primary Orthodontic Insurance
 Insurance Co. name: _____ Policy Owner's Name: _____
 Policy Owner's birth date: _____ Policy Owner's SS #: _____

6. Secondary Orthodontic Insurance
 Insurance Co. name: _____ Policy Owner's Name: _____
 Policy Owner's birth date: _____ Policy Owner's SS #: _____

7. Emergency Contact: _____ **Phone #:** _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature: _____