First Name _____ Last Name _____

Date of Birth _____ Gender: Male or Female (please circle)

Phone number _____

Email _____

Home Address

_____

Responsible Party Information (if patient is a minor)

Relationship to patient _____

First Name _____ Last Name _____

Phone number _____

Email_____

Home address

_____

Is the home address the same as patient? Yes or No (please circle)

Dental Insurance Information

Do you have dental insurance? Yes or No (please circle)

Do you have orthodontic coverage? Yes or No (please circle)

Insurance Name _____

Policy Holder Name _____

Policy Holder Date of Birth _____

Relationship to Patient _____

Subscriber ID # _____ Group # _____

Do you have dual dental/orthodontic coverage? Yes or No (please circle) – If so, please fill the information below

Insurance Name _____

2nd Policy Holder Name _____

2nd Policy Holder Date of Birth _____

Relationship to Patient _____

Subscriber ID # _____ Group # _____

Name of Dentist _____

Any x-rays taken in the last 6 months: Yes or No (please circle) – If so, please attach/send via email to info@mybraceland.com

Referral

Who may we thank for the kind referral?

_____

Preferred days for appointments: (8:40am-5pm) AM/PM Mon/Tue/Wed/Thurs (Please Circle)