

ADULT**ORTHODONTIC ACQUAINTANCE FORM****ADULT****PATIENT INFORMATION**

Date / /	Last Name	First
Sex M F	Age	Birthday / /
Address and Apartment No.(No PO Box #)		
Home Tel.	Email Addr.	
City, State and Zip Code		
Name and relation of Emergency Contact Person		
Telephone of emergency contact person		
Referred By	Patient's Dentist	
Reason For Consultation		
Do you want/need the treatment finished by a certain date?		What date?

FINANCIALLY-RESPONSIBLE-PERSON'S INFORMATION: Part A**Complete Part A if the financially responsible is other than the patient**

Name	Birthday	Relation to Patient
Address and Apartment No (No PO Box #).		
City, State and Zip Code		
Home Tel.	Email Addr.	

FINANCIALLY-RESPONSIBLE-PERSON'S INFORMATION

Occupation	Employer/Company
Empl/Comp Address,City, State	Work Tel.
Social Security No.	
Insurance Carrier Name and ID No.	
Today, what method of payment are you using to pay for this consultation? 1. Cash 2. Credit Card 3. Debit Card 4. Healthplex 5. DC-37 6 UFT Insurance	
If treatment is started what method of payment will you use: 1. Cash 2. Credit/Debit Card....3. Insurance	
Select Preference: 1. Payment in full with discount 2. Initial payment and monthly installments	

PATIENT'S SPOUSE INFORMATION

Name	Occupation
Home Addr and Tel.	
Comp/Empl, Name, Addr. And Tel.	
Soc. Sec No.	

FOR OFFICE USE ONLY**Follow Up:**