IDC PATIENT INFORMATION

WELCOME: *Thank you for selecting Inland Dental Center for your orthodontic needs. This information is necessary for our files and will be considered CONFIDENTIAL.*

Acct. # _____

Date _____ _____ Birthdate Age

Name _____ First Initial Last Occupation

Address _____ City _____ Zip _____ Phone ( ) _____

How Long? _____ Previous Address _____

General Dentist _____ Phone ( ) _____

Physician _____ Phone ( ) _____ Referred by _____

Employed by _____ How Long _____ Work Phone ( ) _____

Business Address _____ Zip _____ Social Security # _____

Spouse's Name _____ Birthdate _____ Occupation _____

Employed by _____ How Long _____ Work Phone ( ) _____

Business Address _____ Zip _____ Social Security # _____

Have we treated other family members? _____

Nearest Relative _____ Relationship _____

Address _____ Phone ( ) _____

DENTAL INSURANCE INFORMATION

Your Insurance Company _____ Phone ( ) _____

Spouse's Insurance Company _____ Phone ( ) _____

Are you covered by any additional Dental Insurance? YES____ NO____ IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insurance company _____

_____ Name of Insured Birthdate

_____ Relationship Social Security Number