

NP LTR SENT: / / A B C	DATE : / / COMPLETED BY:
GP CALLED: / /	APT SCH: / / APT TIME: am pm
LAST CLEANING: / / PANOREX:	Confirmed: / / Spoke To:

Person who will be bringing patient to appointment: ATTITUDE: Pleasant _____ Shy _____ Scared _____ Nervous _____ Angry _____
English is a second language _____ Other: _____

Would you please spell your (child's) first / last name? FIRST NAME: _____ LAST NAME: _____
PREFERS TO BE CALLED: _____

(When appropriate) Do you have a preference as to Orthodontist / office? DR: _____ OFFICE: _____

What is your (child's) date of birth? DOB: _____ (AGE: _____) GENDER F M

For your convenience, we will be sending a package of information which will include: a comprehensive health history, an office brochure and some miscellaneous forms. What is your mailing address?
HOME: _____ SECONDARY ADDRESS: _____
CITY _____ CITY _____
STATE _____ ZIP _____ STATE _____ ZIP _____

Could I get your home phone number? PHONE: _____

Have we had the opportunity to serve your friends or family?

Who is the family dentist? DENTIST: DR. _____
Did Dr. _____ mention our office or did you hear about us from a friend? REFERRER: _____

What are his/her orthodontic concerns? DDS CONCERN: _____
Do you have any other concerns? PATIENT CONCERN: _____

For Child: When I mail the information to you, would you like me to address it to Mr. And Mrs.? FATHER'S NAME (if minor): _____
What is your (husband's/wife's) first name? MOTHER'S NAME (if minor): _____

Are there work or cell phone numbers that we can include in the account information? WORK (if minor- Mom Dad Other: _____): _____
CELL (if minor- Mom Dad Other: _____): _____

Is this the first visit to an Orthodontic office for (Patient's Name)? First Visit Second Opinion Transfer
Comments: _____

IS THERE ANYONE ELSE IN THE FAMILY YOU WOULD LIKE TO HAVE SEEN AT THIS TIME? (Explain Family Care Program) NAME: _____ DOB: / / AGE: _____
APT.: / / TIME: _____ am pm

What to expect: ELEVEN YRS OLD AND OVER: One of our Treatment Coordinators will acquaint you with our office and take digital photographs and an x-ray if needed. Dr. _____ will examine (Patient's name) and use the photographs to discuss any orthodontic concerns. Please plan on being at the office approximately 60 minutes. **TEN YRS OLD AND UNDER:** Please plan on being at the office approximately 30 minutes for the exam. If Dr decides (Patient's Name) is ready to begin treatment at this time, for your convenience we have set aside time for the next step which is diagnostic records. Would you like us to hold that appointment for you? **YES NO**

TRANSFER: What is the name of your previous orthodontist? DR. _____
Address and phone? ADDRESS: _____
PHONE: _____

INSURANCE: We have found that clarifying orthodontic benefits prior to the initial evaluation can be very helpful to our patients will allow us to factor that information into any payment options discussed. Are there possible orthodontic benefits that you would like us to verify? EMPLOYEE'S NAME: _____
DOB: _____ SS#/ID# _____
EMPLOYER: _____
INS. PHONE: _____

Do you have any other questions that I haven't answered? Again, my name is _____. I am really looking forward to meeting both you and _____ on _____ at _____. When you first walk in you will see that we have a computer that patients use to sign in but please stop at the front desk for this first visit so I can say hi. If you prefer, You can fill out your registration information at our website which is _____. You may also want to (have _____) visit our website prior to your visit. It's a great way to get to know us before you even come in!

Date Called: / /	EFFECTIVE DATE: / /	BENEFITS USED?
Spoke To:	WAITING PERIOD: _____ MET: Yes No	REMAINING BENEFITS?
Mail Claims To:	LIFETIME ORTHO MAX \$ _____	SUBMIT: <input type="checkbox"/> Initial Only <input type="checkbox"/> Monthly
	PAID AT _____%	<input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually
	AGE LIMITATIONS? YES NO	CK SENT: <input type="checkbox"/> In Full at Start <input type="checkbox"/> Monthly
		<input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually