



NEW PATIENT INFORMATION (ADULT)

Thank you for choosing Discover Orthodontics! Please complete all applicable information.

1. PATIENT INFORMATION

Today's Date: _____ Date of Birth: _____

Patient's Full Name: _____

Residence Address: _____

Street

City

Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

2. EMPLOYMENT / SPOUSE INFORMATION

Employer: _____ Occupation: _____

Years Employed: _____ Spouse Name: _____ Spouse DOB: _____

Spouse Employer: _____ Spouse Years Employed: _____

3. HOW DID YOU HEAR ABOUT US?

☐ Dentist _____ ☐ Family/Friend _____ ☐ Google ☐ Facebook ☐ Other

4. DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE

Subscriber / Insured Name: _____

Relationship to Patient: _____

Insurance Company: _____

Member ID: _____

Group Number: _____

Subscriber DOB: _____

Employer: _____

SECONDARY INSURANCE (IF APPLICABLE)

Subscriber / Insured Name: _____

Relationship to Patient: _____

Insurance Company: _____

Member ID: _____

Group Number: _____

Subscriber DOB: _____

Employer: _____

Please provide a copy of the front and back of your dental insurance card.

5. EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone Number: _____ Address: _____

6. PREFERRED COMMUNICATION

How would you prefer us to contact you? ☐ Text ☐ Phone Call ☐ Email Preferred #: _____

7. PATIENT ACKNOWLEDGEMENT

I certify that the information provided above is complete and accurate to the best of my knowledge.

I understand that it is my responsibility to notify Discover Orthodontics of any changes to this information.

Patient Signature: _____ Date: _____