

WELCOME TO DR. PETER D. WENDELL'S ORTHODONTIC OFFICE

Adult Form

Appointment date _____

Name _____
Last First MI

Email Address _____

I prefer to be called _____

Birthday ____/____/____ Age _____

SS# _____

Home Address _____

City _____ State ____ Zip _____

____ Single ____ Married ____ Divorced ____ Widowed ____ Separated

Home phone# _____ Cell# _____

Work phone# _____

Employer _____

How long there? _____ Occupation _____

Best Number to reach you? _____

Best time to reach you? _____

Family members seen by us _____

Present/Previous Dentist _____

SPOUSE INFORMATION

His/Her Name _____

Employer _____

Work Phone # _____ Cell # _____

SS# _____

Person Responsible for Account: _____

Work# _____ Cell# _____

Billing Address _____

Relationship _____ SS# _____

Employer _____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDD and the ADA.

Orthodontic Insurance Only

Primary

Insurance Company _____

Insurance Address _____

City _____ State ____ Zip _____

Insurance Phone# _____

Policy Owner's ID# _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Employer _____

Employer Address _____

City _____ State ____ Zip _____

Policy Owner's DOB _____ SS# _____

Secondary

Insurance Company _____

Insurance Address _____

City _____ State ____ Zip _____

Insurance Phone# _____

Policy Owner's ID# _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Employer _____

Employer Address _____

City _____ State ____ Zip _____

Policy Owner's DOB _____ SS# _____

Authorization

This office reserves the right to verify the credit status of potential patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

Signature of Patient

Date

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payments and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office.

Signature of Patient

Date