WELLS ORTHODONTICS

Medical History Form - Adult

Today's Date:

PATIENT INFORMATION

Last Name:	First Name:	Middle Name:
I prefer to be greeted as:	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Sex: ❑ M ❑ F
Birth Date:	Age:	Email:
Social Security #:	Marital Status: Single Married Divorced Separated Widowed Partnered	
Home Address:		
City:	State:	Zip Code:
Home #:	Cell #:	Work #:
Employer:	Occupation:	
When & where are the best times to reach you?		
Whom may we thank for referring you?		
General Dentist:	Last Visit Date:	
Other family members seen here:		
Who is responsible for the account:		

SPOUSE'S INFORMATION

Name:	SSN:	Birth Date:	
Email:	Cell #:		
Employer:	Occupation:	Work #:	
Employer's Address:	City:	State:	Zip Code:

ORTHODONTIC INSURANCE INFORMATION

(Please give your insurance card to the Scheduling Coordinator)

PRIMARY INSURANCE

Orthodontic Coverage? ❑ Yes ❑ No	Dental Coverage? ❑ Yes ❑ No	
Insurance Company:	Insurance Phone #:	
Insurance Address:	Group #:	
City:	State:	Zip Code:
Insured Name:	SSN:	Birth Date:
Employer:	ID#:	Relationship:

SECONDARY INSURANCE

Orthodontic Coverage? ❑ Yes ❑ No	Dental Coverage? ❑ Yes ❑ No	
Insurance Company:	Insurance Phone #:	
Insurance Address:	Group #:	
City:	State:	Zip Code:
Insured Name:	SSN:	Birth Date:
Employer:	ID#:	Relationship:

AUTHORIZATION

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I authorize payment of my group insurance benefits to be made directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examinations, to my insurance company.

Signature:	*Date:*

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