PATIENT'S IDENTIFICATION FORM (ADULT)

Date : _____

Dentist's name : _____Referred by : _____

Last name : _____

First name : _____

Date of Birth : _____ Age : _____Sex : ( ) M ( ) F
day/month/year

Home address : _____

City : _____Postal code :_____

Home phone number : ( ) _____-_____

Cell phone number : ( ) _____-_____

Work phone number : ( ) _____-_____ Extension : _____

E-mail address : _____

Person responsable for the account : _____

Addressof the person responsable for the account :
(if different from yours) _____

City : _____Postal code : _____

Do you have an insurance plan that covers orthodontic treatment? : _____