HULSE ORTHODONTICS

American Association of Orthodontists

invisalign

Welcome to our office! Please fully complete all forms

PATIENT INFORMATION

Date:________________

Patient Name:____ Age:________ DOB:______________ Sex:____________

Home Address:____

City:_________________________ State:_______ Zip:_____________ Home Phone:( ) ________________________

Cell Phone: ( ) ____ **Best Number to be Reached:** Home or Cell

Marital Status: S/M/D/W If Married, Spouse Name:____

Employer:____

Occupation:____

What is your main concern for today's visit?____

____

Whom may we thank for your referral?____

Appointment Confirmations:

Do you prefer ☐Email ☐*Text

*For text confirmations, who is your cell phone provider (i.e. AT&T, T-mobile, Verizon, Sprint) ____________________

FAMILY INFORMATION

Please list names and ages of children if applicable:

RESPONSIBLE PARTY INFORMATION

Name:____

Address:____

Home Phone: ( )___________________________ Cell Phone: ( ) ______________________________

Email:____

EMERGENCY INFORMATION

In case of emergency, who should we contact?____

Phone: ( ) ____ Relationship to patient:________________________

DENTAL INSURANCE INFORMATION

Primary Dental Insurance

Subscriber's Name:__________________________________ Subscriber's ID or SSN:_____________________

DOB:____ Patient Relationship to Subscriber:____________

Name of Insurance Company:________________________ Phone: ( ) _________________________________

Insurance Address:____

Subscriber's Employer:_____________________________ Group or Policy Number:____________________

Secondary Dental Insurance

Subscriber's Name:__________________________________ Subscriber's ID or SSN:_____________________

DOB:____ Patient Relationship to Subscriber:____________

Name of Insurance Company:________________________ Phone: ( ) _________________________________

Insurance Address:____

Subscriber's Employer:_____________________________ Group or Policy Number:____________________

Signature:____

Over