CROCK ORTHODONTICS

NEW PATIENT INFORMATION-ADULT **(Please use blue or black ink)**

Name:		Nickname:	Date of birth:
Address:		City:	Zip:
Primary phone:		Cell phone:	
Age:	Sex *(circle which)*: M F	Marital status *(circle which)*: married single divorced widowed	
Email address:			

Dentist:	Last cleaning:
Physician:	Serious or chronic illness?
Allergic to **latex** *(circle which):* yes no	Taking medications?
Do you take antibiotics for dental appointments? yes no	
Who may we thank for referring you to our office?	
Have we seen any members of your family? yes no	Who?
What are your main concerns with your teeth or bite?	

Your employer:	Work phone:	How long there?
Your social security number:	ID number from insurance card:	
Dental insurance company:	Orthodontic benefits?	

Primary or secondary (circle which)

Spouse/partner

Spouse's name:	Spouse's date of birth:	
Employer:	Work phone:	M F *(circle one)*
Social security number:	ID number from insurance card:	
Dental insurance company:	Orthodontic benefits?	

Primary or secondary (circle which)

Please read and sign both sides.

Insurance Authorization

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize Crock Orthodontics to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to Crock Orthodontics. I permit a copy of this authorization to be used in place of the original. I give Crock Orthodontics, its employees, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, insurance or payment.

Payment Policy

We accept dental insurance assignments, with the understanding that any uninsured portion not covered by your insurance plan is to be paid by you at the time of service. As a courtesy, our office will file all applicable insurance claim forms. Please note that although we strive to provide accurate information, such information is not a guarantee of payment or eligibility with your insurance company and is only an estimate. Your dental insurance plan is a contract between you, your employer, and the insurance company. Depending on your specific insurance plan, your dental insurance may not fully cover our office dental fees for the services we render. The difference between our office dental fees and your insurance reimbursement is your responsibility.

Signature:

The above information is correct and I understand that, where appropriate, credit reports may be obtained.

Signature:

* *

FOR OFFICE USE ONLY

Appointment ________________

Revised Mar 2021