BRIAN SCOTT *D.D.S., M.S., P.C.*
orthodontics exclusively

W E L C O M E !

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

COMPLETE NAME: _____ SOCIAL SECURITY#: _____

SINGLE ❑ MARRIED ❑ (SPOUSE'S NAME) _____ WIDOWED ❑ DIVORCED ❑

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

MALE ❑ FEMALE ❑ AGE: _____ BIRTHDATE: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

PRIMARY DENTAL INSURANCE

SUBSCRIBER NAME: _____ SOCIAL SECURITY#: _____

SINGLE ❑ MARRIED ❑ (SPOUSE'S NAME) _____ WIDOWED ❑ DIVORCED ❑

RELATION TO PATIENT: _____ BIRTHDATE: _____

ADDRESS IF DIFFERENT FROM ABOVE: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

SUBSCRIBER'S EMPLOYER: _____

EMPLOYER ADDRESS: _____

INSURANCE COMPANY: _____

CONTRACT#: _____ GROUP#: _____ SUBSCRIBER#: _____

ADDITIONAL DENTAL INSURANCE

IS PATIENT COVERED BY ADDITIONAL DENTAL INSURANCE? YES ❑ NO ❑

SUBSCRIBER NAME: _____ SOCIAL SECURITY#: _____

RELATION TO PATIENT: _____ BIRTHDATE: _____

ADDRESS IF DIFFERENT FROM ABOVE: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORKPHONE: _____

SUBSCRIBER'S EMPLOYER: _____

EMPLOYER ADDRESS: _____

INSURANCE COMPANY: _____

CONTRACT#: _____ GROUP#: _____ SUBSCRIBER#: _____

Member American Association of Orthodontists