SAWYER ORTHODONTICS

Dr. Amy Smith Sawyer

ADULT PATIENT INFORMATION

Date:_____

Name:_____
Last First Middle

Address:_____
Street City Zip

How long at this address?_____Own or Rent?_____

Birthdate:_____ SSN: _____

Home Phone_____ Cell/Other Phone_____

Email: _____

Employer:_____Occupation:_____

Marital Status: _____ Spouse's Name:_____ Phone:_____

Best number to contact you? (circle one): Home Work Cell/Other

Other family members treated at our office:_____

Who may we thank for referring you to our office?_____

DENTAL INSURANCE INFORMATION

**Please provide all information below. It is necessary to verify your orthodontic benefits*

Insured's Name:_____ Insured's SSN: _____
Insured's Address (if different from above):_____
Insured's DOB:_____
Insurance Co.:_____ Ins. Co. Phone:_____
Member ID:_____ Group #:_____
Ins. Co. Address:_____

EMERGENCY CONTACT

Name:_____ Phone: _____

Name of person financially responsible for account (if different from above):_____
Resp. party Phone:_____ Resp. Party Address:_____
Resp. party Email:_____

I understand that, where appropriate, credit bureau reports may be obtained. (Please note: Credit reports obtained by our office have no effect on credit scores and will not appear on credit reports.)

Responsible Party's Signature:_____
Updates (date & initial)_____