Brown Orthodontics

Welcome

"Your Smile is Our Specialty"

PATIENT INFORMATION

PATIENT'S NAME: _____ Nickname: _____
Last First Middle

Birthdate: _____ Age: _____ Male / Female

Address: _____
Street City Zip

Email Address: _____

Daytime #: _____ Cell / Home / Work Evening #: _____ Cell / Home / Work

Dentist Name: _____ Orthodontic Concerns: _____

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

Office Location Preference?: ☐ East Vancouver ☐ West Vancouver

If patient is a minor, give parents or legal guardian's name: _____

School: _____ Grade: _____

Siblings: _____

RESPONSIBLE PARTY INFORMATION

Self/Father/Mother Name: _____ SS#: _____

Address: _____ How Long? _____
Street City Zip

Email Address: _____

Daytime #: _____ Cell / Home / Work Evening #: _____ Cell / Home / Work

Employer: _____ Occupation: _____ How Long? _____

Spouse/Father/Mother Name: _____ SS #: _____

Address: _____ How Long? _____
Street City Zip

Email Address: _____

Daytime #: _____ Cell / Home / Work Evening #: _____ Cell / Home / Work

Employer: _____ Occupation: _____ How Long? _____

I understand that, when financing, credit bureau reports may be obtained. Signed _____

DENTAL INSURANCE INFORMATION

Policy Holder's Name: _____ Birthdate: _____ Employer: _____

Primary Ins. Company: _____ Ins. Billing Address: _____

Group #: _____ Ins. ID#: _____ Ins. Co Phone # ( ) _____

Policy Holder's Name: _____ Birthdate: _____ Employer: _____

Secondary Ins. Company: _____ Ins. Billing Address: _____

Group #: _____ Ins. ID#: _____ Ins. Co Phone # ( ) _____

I authorize the release of information to my insurance company and Constance M. Brown, DDS to bill and receive direct payment for services.
Signed _____