

Welcome to Wittler Orthodontics!

Date _____

Patient's name _____
Last First Middle Nickname

Address _____
Street City State Zip Code

Home Phone _____ Cell Phone _____ Email address _____

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

I WOULD LIKE TO RECEIVE APPOINTMENT CONFIRMATION BY (please circle) TEXT yes no EMAIL yes no

I consent to the dental practice using my cell phone number to call or text regarding appointments and to call regarding treatment, insurance, and my account. I understand I can withdraw my consent at any time. My cell phone number is _____ (include area code) _____ (initial)

Responsible Party Information

Parent's marital status: Married Divorced Widowed Single Separated

Father's name _____
Last First Middle

Address (If different from patient) _____
Street City State Zip code

Home Phone (If different from patient) _____ Work/Cell Phone _____

Employer _____ Number of year's employed _____

Mother's name _____
Last First Middle

Address (If different from patient) _____
Street City State Zip code

Home phone (If different from patient) _____ Work/ Cell Phone _____

Employer _____ Number of year's employed _____

Who is responsible for this account? _____

Who is responsible for making appointments? _____

Primary Orthodontic Insurance Information

Insured's name _____

Insured's ID Number _____

Insured's birth date _____

Insurance Company _____

Insurance Co. Address _____

Insurance Co. Phone _____