David S. Lavine, D.D.S., M.S.
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Adult Patient Information:

Date: ___________________

Patient's Name ____

Male or Female (please circle)

Date of Birth: ____________________________ Age: ____________ SS# ___________________________

Address: ____

____

Home # ____________________________________ Cell # _____________________________________

Work # _____________________________________ Email: ____________________________________

General Dentist: ____ Phone # ________________________

Date of Last Visit to General Dentist: __________________________________

Whom may we thank for referring you? ____

Family Members Who Have Had Orthodontic Treatment at this Office: __________________________________

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Have you consulted an Orthodontist before? Yes ________ No _________

If yes, whom: ____

Why are you seeking Orthodontic Care? ____

Insurance Information:

Do you have Orthodontic Insurance? Yes ________ No _________

Name of Policy Holder: ____

Name of Insurance Carrier: ____

ID# _______________________________________ Date of Birth: (Policy Holder) ______________________

Social Security #: (Policy Holder) ____

Is the patient covered by additional Orthodontic Insurance? Yes ________ No _________

Name of Policy Holder: ____

Name of Insurance Carrier: ____

ID# _______________________________________ Date of Birth: (Policy Holder) ______________________

Social Security #: (Policy Holder) ____