Varble Orthodontics, P.C.

Patient Registration - Adult

Patient Name _____ Birthdate_____

Patient's Employer _____ Work Phone_____

Spouse's Name _____

Spouse's Employer _____ Work Phone _____

Patient's Dentist Dr. _____

Who referred you to our office? _____

Have you worn braces before? Yes ___ No ___

Insurance

Do you have orthodontic insurance? Yes ___ No ___ PPO_____

Insurance Name_____

Insurance Address _____

Subscriber Name_____ DOB _____ SSN _____

Policy/Group # _____

I authorize release of any information relating to a claim. I understand that I am responsible for all costs of dental treatment.

_____ _____

Signed (Patient) Date

I hereby authorize payment of dental benefits, otherwise payable to me directly to Varble Orthodontics, P.C.

_____ _____

Signed (Insured Person) Date

HIPAA

I, _____, have received a copy of this office's Notice of Privacy Practices.
(Patient's Name)

_____ _____

Signed (Patient) Date