GLYNN ORTHODONTICS | Ellen J. Glynn, DDS MDS
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NEW PATIENT INFO - ADULT AND CHILD

Name: ____ Date: _______________________
Date of Birth: ________________________ Male/Female Height: ________ Weight: _________
Address: ____
City:____________________________ Zip Code: ________ Email:__________________________
Home Phone: ______________________________ Cell: __________________________________
Preferred method of contacting you? ____

FOR CHILDREN:
Mother's Name: _________________________________ Employer: _________________________
Business Address: ____
Father's Name: _________________________________ Employer: __________________________
Business Address: ____
Sisters? Names and Ages: ____
Brothers? Names and Ages: ____

Whom may we thank for your referral? ____
Dentist's Name: ____________________________ Last Dental Visit: _________________________
What is your reason for seeking an orthodontic consultation? ____________________________________
____

Is there anything you'd like to change about your/your child's smile? _______________________________
____
Have there been any accidents involving your/your child's face or teeth?___________________________
____
Have you consulted an orthodontist previously? ____
____

Do you have insurance that includes orthodontic treatment? _____________________________________
Insurance Name: ____________________________ Group # ________________________________
Address: ____ Phone: ____________________________
Name of Insured: ____________________________ Relationship to patient: ____________________
Insured's Social Security Number :_____________________________ Date Of Birth: _______________

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Address: ____ Phone: ____________________________

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