James T. Phelan, DDS, MSD ♣ R. Thomas Phelan, DDS, MS
Specialists in Child & Adult Orthodontics

Date:

ADULT INFORMATION FORM

Patient Name____ ☐ Male ☐ Female

Social Security #_______________Birth Date___________Driver License #________________

Home Address ____

City_________________________________State__________ Zip________________

Primary Phone #______________________ ☐ home ☐ cell Ok to leave Message? ☐ Y ☐ N

Secondary Phone #_____________________ ☐ home ☐ cell ☐ other Ok to leave Message? ☐ Y ☐ N

Email Address ____

Employer's Name_______________________________Occupation_____________________

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse Name ____

Social Security #________________________________Birth Date_____________________

Employer's Name_______________________________Occupation_____________________

Phone #_____________________________Relation to you__________________________

EMERGENCY CONTACT INFORMATION

Emergency Contact Name (outside of household)_____________________________________

Phone #_____________________________Relation to you__________________________

Address ____

City_________________________________State__________ Zip________________

Person(s) OK to release appointment or medically related information to concerning yourself.

Name_______________________________Relation to you__________________________

PRIMARY DENTAL INSURANCE

Policy Holder's Name ______________________________

Policy Holder's Birth Date______________________Policy Holder's SSN ______________________

Employer______________________________ Relation to Patient______________________

Insurance Company Name ______________________________

Insurance Phone Number ______________________________

Group Number ______________________________

Policy Number______________________________

SECONDARY DENTAL INSURANCE

Policy Holder's Name ______________________________

Policy Holder's Birth Date______________________Policy Holder's SSN ______________________

Employer______________________________ Relation to Patient______________________

Insurance Company Name ______________________________

Insurance Phone Number ______________________________

Group Number ______________________________

Policy Number______________________________