



Ebert Orthodontics
— Donna Ebert, D.D.S., M.D.S. —

ADULT PATIENT INFORMATION

SELF

Title Dr. _____ Mr. _____ Mrs. _____ Ms. _____ Other _____

Name _____
Last First M.I.

Prefers to be called _____

ADDRESS

Street _____

City _____ State _____ Zip _____

How long at this address? _____

Previous Address if less than 2 years _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

The best number to contact me is: H ____ C ____ W ____

Employer _____ How Long? _____

Occupation _____

Dental Ins. _____

Dental Ins. I.D.# _____ Birthdate _____

SPOUSE _____

SPOUSE OR OTHER RESPONSIBLE PARTY

Title Dr. _____ Mr. _____ Mrs. _____ Ms. _____ Other _____

Name _____
Last First M.I.

Prefers to be called _____

ADDRESS

Street _____

City _____ State _____ Zip _____

How long at this address? _____

Previous Address if less than 2 years _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

The best number to contact me is: H ____ C ____ W ____

Employer _____ How Long? _____

Occupation _____

Dental Ins. _____

Dental Ins. I.D.# _____ Birthdate _____

SPOUSE _____

OTHER INSURED: NAME _____ RELATIONSHIP TO PATIENT: _____
Last First M.I.

DENTAL INS CO. _____ DENTAL INS ID# _____

NAME OF DENTIST	DATE OF LAST VISIT	WHO MAY WE THANK FOR RECOMMENDING US
RELATED PATIENTS THAT ARE OR HAVE BEEN UNDER OUR CARE		NAMES & BIRTHDATES OF CHILDREN
1		1
2		2
3		3

EMERGENCY CONTACT INFORMATION

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU _____
Last First Relationship

ADDRESS _____ DAYTIME PHONE _____
Street City State Zip

To the best of my knowledge, the above information is complete and correct. I give my permission for the taking of photographs and necessary x-rays before, during and after treatment and to the use of photographs and records made in the process of examination, treatment and retention to be used for the purposes of demonstrations, office marketing, research, education or publication in professional journals.

Signature _____ Date _____