Office Use Only

PR#____________

Appt Date:

_____/______/_____

*** **Please Note** ***

We do not accept new patients who currently have braces or other Orthodontic appliances.

Thank you

University of Maryland School of Dentistry Department of Orthodontics

Orthodontic Screening Information:

Patient Information:

________________________ __________________ ____________________________

First Name Middle Last Name

____________________________________ ____________________________

Address City State Zip

Birthdate: ______/_____/_______ ______ Sex: Male ☐ Female ☐

Month Day Year Age

Preferred Language: (if not English):______________________ Email: ________________________________

Parent/Legal Guardian: (Please fill out if patient is under 18 years of age)

____________________ ________________ ___________________________

First Name Middle Last Name

Birthdate: _____/_____/_______ Soc Sec # _______-______-________

Relationship to patient: _________________________

Primary Phone Number: _____________________ _______________________ _____________________

Type (circle one): Cell/Home/Work Cell/Home/Work Cell/Home/Work

Insurance Information: Do you/your child have insurance coverage? YES NO

Is this a Medical Assistance Plan? YES NO (Please note: MA coverage for ortho is only for children under 21 years of age)

Insurance Policy #____________________________ Insurance Name: ____________________________

**** PLEASE SEND A COPY OF THE FRONT AND BACK OF INSURANCE CARDS ****