SHANNON HILGERS NISSEN
ORTHODONTICS

ADULT New Patient Form Page 1 of 2

Welcome To Our Office!

Dr. Nissen may wish for you to have records taken for a more detailed diagnosis. These records would not be taken without your permission or shared with others under current HIPPA guidelines.

Personal:

Patient's Name: _____Age: _____
Address: _____City:_____
State: _____ Zip: _____DOB: _____Sex: M F
Home Phone: _____Cell Phone: _____
Email address:
_____

Has anyone in your family had orthodontic treatment? Yes _____No _____
If yes, by whom? _____City/State _____
Who is your General Dentist? _____City/State _____
How did you hear about our office? Google _____Facebook _____Dentist Referral_____Patient Referral (If yes, by whom?):_____Other:_____

Are you interested in: Braces_____Invisalign_____Clear Braces _____Retainers _____Sleep Apnea _____

Billing:

Do you have any Orthodontic Insurance Benefits?
If yes, please complete the following:
Subscriber:_____ Relationship to you:_____
Insurance Company:_____ Employer:_____
Subscriber DOB:_____ Subscriber ID # OR SSN#:_____
Insurance phone number_____

Do you have Dual Insurance?
If yes, please complete the following:
Subscriber:_____ Relationship to you:_____
Insurance Company:_____ Employer:_____
Subscriber DOB:_____ Subscriber ID or SS#:_____
Insurance phone number: _____

I consent to photographs and x-rays being taken. That they may be used for illustration/ documentation of my treatment.

Signature: _____ Date: _____