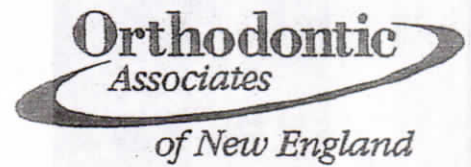


DATA SHEET - ADULT (over 18)



PATIENT INFORMATION:

Patient's Name _____ Nickname _____
Address _____ Male/Female _____
_____ Home Phone (____) _____
Date of Birth _____ Age _____ Cell Phone (____) _____
Self: Occupation _____ Daytime Phone (____) _____
Spouse: Occupation _____ Daytime Phone (____) _____

PRIMARY ORTHODONTIC INSURANCE:

SECONDARY ORTHODONTIC INSURANCE:

Insured's Name _____ Insured's Name _____
Relation to Patient _____ Relation to Patient _____
Insured's Birth Date _____ Insured's Birth Date _____
Insured's Social Security No. _____ Insured's Social Security No. _____
Insured's Employer _____ Insured's Employer _____
Insurance Company _____ Insurance Company _____
Insurance Co. Phone No. (____) _____ Insurance Co. Phone No. (____) _____

DENTAL HISTORY:

Family Dentist _____ City _____
Date of Last Cleaning _____
Previous Dental Problems _____
History of Periodontal Disease? _____
Have any teeth been injured, loosened or knocked out? _____
Describe in your own words your main orthodontic concern: _____

Who recommended you to our office? _____
Any family members in treatment with us? _____

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Orthodontic Associates of New England/James R. Metcalf, D.M.D., P.C. to release any information, including the diagnosis and the records of any treatment rendered to me, to Third Party Payers and/or Health Practitioners.

Signed _____ Date _____