



**Brodie L. Bowman, DMD**

Specialist in Orthodontics & Dentofacial Orthopedics  
CHILDREN + TEENS + ADULTS

### PATIENT INFORMATION - ADULT

Date \_\_\_\_\_  
 Title \_\_\_\_\_ Legal Name \_\_\_\_\_  
 Preferred Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_  
 E-Mail Address \_\_\_\_\_ Occupation \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone 1 \_\_\_\_\_ Phone 2 \_\_\_\_\_  
 Employer \_\_\_\_\_ Marital Status \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_  
 Referred By \_\_\_\_\_ Hobbies/Interests \_\_\_\_\_  
 Past or Present Family Members in Treatment \_\_\_\_\_  
 Have you Consulted an Orthodontist Before? \_\_\_\_\_  
 Why are you seeking orthodontic treatment? \_\_\_\_\_

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### PRIMARY INSURANCE INFORMATION

Subscriber's Name \_\_\_\_\_ DOB \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_  
 Group Number \_\_\_\_\_ Subscriber ID/SS# \_\_\_\_\_

### SECONDARY INSURANCE INFORMATION

Subscriber's Name \_\_\_\_\_ DOB \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_  
 Group Number \_\_\_\_\_ Subscriber ID/SS# \_\_\_\_\_

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Signature \_\_\_\_\_ Date \_\_\_\_\_  
 ( Parent / Legal Guardian )

