GLYNN ORTHODONTICS | Ellen J. Glynn, DDS MDS
655 Camino de los Mares #119, San Clemente, CA 92673
info@GlynnOrthodontics.com | 949-488-0600

Name: _____ Date: _____
Date of Birth: _____ Male/Female Height: _____ Weight: _____
Address: _____
City:_____ Zip Code: _____ Email:_____
Home Phone: _____ Cell: _____
Preferred method of contacting you? _____

FOR CHILDREN:
Mother's Name: _____ Employer: _____
Business Address: _____
Father's Name: _____ Employer: _____
Business Address: _____
Sisters? Names and Ages: _____
Brothers? Names and Ages: _____

Whom may we thank for your referral? _____
Dentist's Name: _____ Last Dental Visit: _____
What is your reason for seeking an orthodontic consultation? _____
_____

Is there anything you'd like to change about your/your child's smile? _____
_____
Have there been any accidents involving your/your child's face or teeth?_____
_____
Have you consulted an orthodontist previously? _____
_____

Do you have insurance that includes orthodontic treatment? _____
Insurance Name: _____ Group # _____
Address: _____ Phone: _____
Name of Insured: _____ Relationship to patient: _____
Insured's Social Security Number :_____ Date Of Birth: _____

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