



braces for adults & children

# Welcome (Adult)

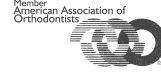
to the office of

**STEVEN T. JUNG, D.M.D., M.S.**

Specialist in Orthodontics

1417 Tracy Blvd.  
Tracy, CA 95376  
(209) 835-0977

8265 Village Pkwy., Ste. D  
Dublin, CA 94568  
(925) 828-6550



## About You

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First MI

I prefer to be called: \_\_\_\_\_

Single  Married  Divorced  Widowed  Separated

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Age: \_\_\_\_\_  Male  Female

Home Address: \_\_\_\_\_

Home Phone #: (\_\_\_\_) \_\_\_\_\_

Cell / Other #: (\_\_\_\_) \_\_\_\_\_

Work #: (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Email Address: \_\_\_\_\_

Driver's License #: \_\_\_\_\_

SS #: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Where & when are best times to reach you?

Whom may we Thank for referring you? (name, address, phone)

Other family members seen by us?

General Dentist: (name, address, phone) \_\_\_\_\_

\_\_\_\_\_

## Orthodontic Insurance

### Primary

Orthodontic Coverage:  No  Yes

Dental Coverage:  No  Yes

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Email: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured's S.S. #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

FOR OFFICE USE ONLY

Insurance Benefits: \_\_\_\_\_

### Secondary

Orthodontic Coverage:  No  Yes

Dental Coverage:  No  Yes

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Email: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured's S.S. #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

FOR OFFICE USE ONLY

Insurance Benefits: \_\_\_\_\_

