James W. Logeman, D.D.S., M.S.
ORTHODONTICS

PRACTICE LIMITED TO ORTHODONTICS

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Cincinnati, Ohio 45236
(513) 791-0260

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318 Reading Road
Mason, Ohio 45040
(513) 398-0133

Please take a few minutes to thoroughly complete this form, thank you.

Patient Information

Date:______________________

Mr. Mrs. Miss Ms. Dr.

Patient's Name (last, first Middle)____________________________________Preferred Name:_____________

Address_______________________________City______________________State________Zip__________

Date of Birth______________________ Age______________ SS#_________________________________

Cell Phone____________________________ Email Address:____

Home Phone___________________________Work Phone_____________________________ext___________

Employer______________________________________Occupation__________________________________

Whom may we thank for referring you to our office?____

Current Dentist__________________________________ Last Visit____________________________

Previous Orthodontic Treatment? Yes No How long ago?____

Other family members seen by us?____

Dental Concerns___________________________________Allergies__________________________________

Special and/or Medical circumstances you would like to share?____

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Martial Status? Single Married Separated Widowed Divorced

Spouse's Name (last, first, MI) ____

Mailing Address (if different)_______________________City______________State_____Zip____________

Cell Phone_____________________Home Phone___________________Work Phone______________________

Email Address:___________________________________ Date of Birth________________________________

Employer______________________________________ Occupation__________________________________

Insurance Information

Insured's Name ____ Relationship to Patient _____________________

Insured's DOB __________________________ Social Security Number___________________________________

Primary Dental Insurance Company: ____

Insurance Claims Address _______________________________________State ________Zip_______________

Phone _______________________________________

Group Number: __________________________________ ID Number: ____________________________________

Employer: ____

Orthodontic Lifetime Max: _____________________ Amount Used: ___________________________

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Insured's Name ____ Relationship to Patient _____________________

Insured's DOB __________________________ Social Security Number___________________________________

Secondary Dental Insurance Company: ____

Insurance Claims Address _______________________________________State ________Zip_______________

Phone _______________________________________

Group Number: __________________________________ ID Number: ____________________________________

Employer: ____

Orthodontic Lifetime Max: _____________________ Amount Used: ___________________________

Emergency Information

Name and relationship of nearest emergency contact not living with you___________________________________

Address____Phone____

I authorize release of insurance information, Printed Name____

Signature____

I understand that where appropriate, credit bureau reports may be obtained.

Signature ____