Makers of great smiles.
ensleyortho.com

3810
sw hall boulevard
beaverton, oregon
97005

tel: 503-643-9509
fax: 503-646-2886

Welcome to our practice!

We appreciate your confidence in choosing us for your orthodontic care. We are committed to providing the highest quality care and a great experience for our patients. The result is beautiful, health teeth and a confident smile that will last a lifetime.

Your initial appointment will take approximately 80 minutes and begins with complimentary digital photographs and radiographs. We encourage you to invite your spouse, partner, or other involved persons to be present for this appointment so they can receive all the information and decisions about treatment can be made.

Dr. Ensley will examine your teeth, mouth and profile. We will then give you a report with the following information:

- Identification of any orthodontic problems and their consequences
- Best customized treatment plan to correct the problem
- Estimated length of treatment time
- Best timing to begin treatment
- Fee for treatment, estimated insurance coverage, and personalized financial arrangements

The initial examination and radiographs are complimentary. If treatment is indicated, it will be necessary for us to take diagnostic records. These consist of periapical radiographs and impressions for plaster models of your teeth. It may be possible to have these done the same day.

Enclosed you will find an Information Form and HIPAA consent form to be completed prior to your appointment. Please bring these, as well as your insurance information (if applicable), with you to your appointment.

We look forward to meeting you!

Sincerely,

Jareen Lyda

Practice Coordinator

tel: 503-643-9509
fax: 503-646-2886

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Brace yourself.
It's gonna be fun!
ensleyortho.com

We like to be in the know.

Thank you for providing this important information to help us serve you best. If you have any questions or need assistance, just ask. We're happy to help!

DATE _____

ACCOUNT NUMBER _____

ensley ORTHODONTICS

Patient Information

NAME _____ DATE OF BIRTH _____ AGE _____ [M] [F]

ADDRESS (STREET, CITY, STATE, ZIP) _____

HOME PHONE _____ MOBILE PHONE _____ WORK PHONE _____

E-MAIL _____

IF THE PATIENT IS A MINOR, PLEASE PROVIDE BOTH PARENTS OR GUARDIAN NAMES _____

PATIENT LIVES WITH WHOM _____ RELATIONSHIP TO PATIENT _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

Responsible Party

NAME _____ DATE OF BIRTH _____ SSN _____

MARITAL STATUS: [S] SINGLE [M] MARRIED [D] DIVORCED [W] WIDOWED [SP] SEPARATED

RESIDENCE ADDRESS _____ [O] OWN [R] RENT

MAILING ADDRESS (IF DIFFERENT) _____

PREVIOUS ADDRESS (IF LESS THAN 3 YEARS) _____

HOW LONG HAVE YOU BEEN AT THIS ADDRESS? _____ HOME PHONE _____ WORK PHONE _____

EMPLOYER _____ OCCUPATION _____ YEARS EMPLOYED _____

SPOUSE'S NAME _____ RELATIONSHIP TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ YEARS EMPLOYED _____

SPOUSE SSN _____ SPOUSE DATE OF BIRTH _____ SPOUSE WORK PHONE _____

Insurance Information

INSURED'S NAME _____ INSURED'S ID NUMBER _____

DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

INSURANCE COMPANY _____ GROUP NUMBER _____ LOCAL NUMBER _____

INSURANCE COMPANY ADDRESS _____ PHONE _____

DO YOU HAVE SECONDARY COVERAGE? [Y] [N]

INSURED'S NAME _____ INSURED'S ID NUMBER _____

DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

INSURANCE COMPANY _____ GROUP NUMBER _____ LOCAL NUMBER _____

INSURANCE COMPANY ADDRESS _____ PHONE _____

Emergency Information

NEAREST RELATIVE NOT LIVING WITH PATIENT _____ RELATIONSHIP _____

ADDRESS _____

HOME PHONE _____ MOBILE PHONE _____

Please take a moment to complete the reverse side of this form.

Submit all Forms