ORTHODONTIC REGISTRATION

Date _____

Name _____ Nickname Preferred _____

Date of Birth _____ Address _____

Age _____ _____

Gender _____ _____

How did you hear of us? _____

Dentist's Name_____ Physician's Name _____

Employer _____ Physician's Phone #_____

Work # _____ Spouse's Name _____

Home # _____ Employer _____

Cell # _____ Cell # _____

Email _____ Email _____

SS# _____ SS# _____

Please list any interests, sports or hobbies _____

_____

Have you ever had orthodontic treatment before? Yes _____ No _____

Has any other family member received orthodontic care? Yes _____ No _____

Do you have orthodontic insurance? Yes _____ No _____

Would you like our office to bill your insurance for you? Yes _____ No _____

If yes, please let the front desk know <u>now</u> and they will be happy to gather the necessary information to process your claims for you

To our patients:

We keep a record of the health care services we provide to you. You may ask us to see and copy that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it at our front desk.

<u>Emergency Information:</u>

Name of nearest relative
Or friend not living with you _____ Phone # _____

Address_____

Signature: _____ Date: _____