ORTHODONTIC REGISTRATION

Date _____

Patient Name_____ Nickname Preferred_____

Date of Birth _____ Address _____

Age _____ _____

Gender _____ _____

How did you hear of us? _____

Dentist's Name_____ Physician's Name_____

Father's Name _____ Mother's Name _____

Employer _____ Employer _____

Cell # _____ Cell # _____

Home # _____ Home # _____

Work # _____ Work # _____

Email _____ Email _____

SS# _____ SS# _____

Is the child living with BOTH parents? _____

If not, whom is the child living with? _____

Please list any musical instruments, sports or hobbies _____

_____

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

Do you have orthodontic insurance? Yes _____ No _____

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 you 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.

Emergency Information:

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

Address_____

Signature of Parent or Guardian _____ Date _____