

Patient ID#

Registration

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Specialist in Orthodontics

Welcome to our office! Please assist us in answering the following (complete in ink):

Patient's Name:(Mr. Mrs. Ms. Dr.) _____
(Last) (First) (Middle)

Address: _____ S.S.# _____
(Street) (City) (Zip)

Date of Birth: _____ Sex: M / F Phone: (H) _____ (W) _____

Emergency Contact Person: _____ Phone: _____
(Name) (Relationship)

School Attending: _____ Grade: _____ Or Occupation: _____

Hobbies / Interests: _____ Responsible party e-mail: _____
Patient e-mail: _____

(If patient is a minor)

Mother: (Mrs. Ms. Dr.) _____ Marital Status: S M D W Sep.

Employer/Occupation: _____ S.S.# _____

Father: (Mr. Dr.) _____ Marital Status: S M D W Sep.

Employer/Occupation: _____ S.S.# _____

(If patient is an adult)

Spouse/Other: _____ Phone:(H) _____ (W) _____

Employer/Occupation: _____ S.S.# _____

Who will pay this account? _____

Do you have insurance that may cover any part of orthodontic services? Yes No

If yes→ Name of Employer: _____ Phone: _____

Address: _____ Policy # _____

Name of Insurance Company: _____ Phone: _____

We do not directly accept insurance assignment, but we will assist you in completing and submitting your insurance forms so that you may be reimbursed. Payment is due at the time services are rendered unless prior arrangements have been made.

Patient's Family Physician: _____ City: _____ Ph: _____

Date of most recent physical: _____ Current Height: _____ Weight: _____

Is the patient currently taking any medication? Yes No If yes, please list: _____

Is the patient currently being treated for any medical condition? Yes No If yes, please describe: _____

(over)

