

REGISTRATION AND HEALTH HISTORY

Account # _____

What is it about your teeth that you would like to fix? _____

Patient's Name _____ **M/F** _____ **Birthdate** _____ **Age** _____

Patient's Address _____ **City** _____ **Zip** _____ **Home Ph#** _____

Mother: _____ **Cell#** _____ **Wk Ph#** _____ **Ext#** _____

Mother employed by _____ **Address** _____ **City** _____ **Zip** _____

How long? _____ **Position** _____ **Phone No.** _____ **Ext:** _____

Social Security No. **Driver's License No.** _____ **Mother's date of birth** _____

Father: _____ **Cell#** _____ **Wk Ph#** _____ **Ext#** _____

Father employed by _____ **Address** _____ **City** _____ **Zip:** _____

How long? _____ **Position** _____ **Phone No.** _____ **Ext:** _____

Social Security No. **Driver's License No.** _____ **Father's date of birth** _____

School _____ **Whom may we Thank for referring you** _____

Patient's dentist _____ **Address** _____

City _____ **Zip Code** _____ **Phone** _____

Patient's medical doctor _____ **Phone** _____

Orthodontic Insurance _____ **Phone #** _____ **Employer** _____

Employee Name _____ **Social Security No.** _____ **Group #** _____

Signature _____ **Date** _____

Parent/Gaurdian