PATIENT INFORMATION

Last Name _____First Name _____ Middle Initial _____

I prefer to be called (example: Bob not Robert, Susan not Sue) _____

Sex _____ Age _____ Birth Date _____

Home Address _____ City _____

State _____ ZIP Code _____ Home Phone (_____)_____

Does patient attend school? ___ yes ___ no If yes, School _____ Grade _____

FAMILY INFORMATION

(Adult patients may omit this section)

List the names and ages of brothers and/or sisters _____

Father or Guardian _____ Occupation _____

Marital Status: Married ___ Divorced ___ Separated ___ Widowed ___ Single ___

If home address and telephone are different from patient:

Home Address _____ City _____

State _____ ZIP Code _____ Home Phone (_____)_____

Employer _____ Work phone (_____)_____

Employer's address _____

City _____ State _____ ZIP Code _____

Mother or Guardian _____ Occupation _____

Marital Status: Married ___ Divorced ___ Separated ___ Widowed ___ Single ___

If home address and telephone are different from patient:

Home Address _____ City _____

State _____ ZIP Code _____ Home Phone (_____)_____

Employer _____ Work phone (_____)_____

Employer's address _____

City _____ State _____ ZIP Code _____

FINANCIAL INFORMATION

FOR ADULT PATIENTS: (see other side for dependent adults and minor children)

Please check one: ___ Patient ___ Spouse is responsible for financial portion of treatment

If spouse, name _____

Employment information for person financially responsible:

Employer _____ Work phone (_____)_____

Employer's address _____

City _____ State _____ ZIP Code _____

Signature of responsible party _____

FOR PATIENTS WHO ARE MINOR CHILDREN OR FINANCIALLY DEPENDENT ADULTS:

Our current office policy requires that all accounts are in <u>one</u> person's name only. If the patient and both parents live at the same address, please choose one parent to be responsible. If the patient and both parents do not live at the same address, the responsible party will be the parent who has called to schedule the initial examination appointment. If the patient is living with a guardian, the guardian will be considered the person financially responsible.

Name of person responsible for financial portion of treatment _____

Relationship to patient _____

_____

Signature of person accepting financial responsibility Date

If the patient is covered by a dental insurance plan with an orthodontic benefit, please complete an insurance information form.

This registration form was updated:

Date _____ Signature _____

Date _____ Signature _____

Date _____ Signature _____

ORTHODONTIC EXAMINATION

Profile _____ Facial Symmetry _____

Habits (Swallow) _____ Musculature (Lips) _____

TMJ Right _____ Left _____

TMJ Comments _____

_____

Molar Relationship Right _____ Left _____ Cuspid Relationship Right _____ Left _____

Overjet _____ Overbite _____ Midline _____

Teeth Present _____ Crossbite _____

Tooth – Jaw Ratio Maxilla _____ Mandible _____

Functional Deviations _____ Occlusial Curve _____

Caries _____ Oral Hygiene _____ Perio _____

Dental Aberrations _____ Smile Consonance _____

_____ Space Loss _____

_____ Gingival Show on Smile _____

_____ Missing/Impacted Teeth _____

_____ Incisal Show at Repose _____