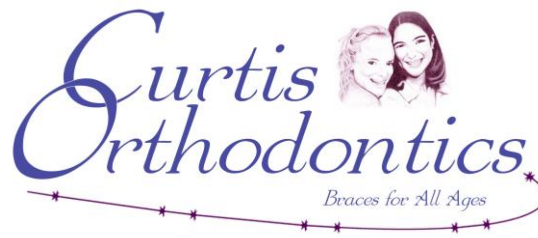

We are pleased to welcome you to our practice. Please take a few minutes to fill out the form as completely as you can. Please ask us if you have any questions.

Patient Information

Date ____ / ____ / ________

Patient ________________________________ ________
First Name M.I.

____
Last Name

Prefers to be called: ____________________________
Common Name

Address____

____
City State Zip

Phone: ___________________________________

Gender: ☐ M ☐ F ☐ Other ☐ Transgender

Age ______ Birthdate ____ /____ /________

Family Dentist: __________________________________

Last Dental Visit (month) ______ (year) _____

Referred By:
- ☐ Family Dentist
- ☐ Other:

____

Reason for consultation (Chief Complaint):

____

Have other family members been treated at our office?

☐ Yes ☐ No If so, who?

____

Have you been seen by another orthodontist? ☐ Yes ☐ No

If patient is employed:

Occupation _____________________________________

Employer _______________________________________

Work Phone ______________________________

If patient is a student:

School ____________________________ Grade _______

If patient is married/partnered:

Spouse/Partner's Name ____________________________

Confirming Appointments

☐ Home Phone ☐ Text Message ☐ E-Mail ☐ Other

Cell Phone: ____________________________________

E-Mail: _______________________________________

If patient is a minor:

Father's Name __________________________________

Occupation _____________________________________

Employer _______________________________________

Work Phone ______________________________

Mother's Name __________________________________

Occupation _____________________________________

Employer _______________________________________

Work Phone ______________________________

Person(s) responsible for this account:

☐ Self ☐ Father ☐ Mother ☐ Other

If other:

Name ____

Relationship to patient ____________________________

Phone _____________________________