Curtis Orthodontics
Braces for All Ages

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

Home Phone# _____

Sex: M F

Age _____ Birthdate ____ /____ /_____

Patient SS# _____-_____-_____

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 a student:

School _____ Grade _____

If patient is married:

Spouse's Name _____

Spouse's Employer _____

If patient is employed:

Occupation _____

Employer _____

Employer Address _____

Employer Phone# _____

Responsible Party Information

If patient is a minor:

Father's Name _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Mother's Name _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Person responsible for this account:
Self Father Mother Other

If other:

Name _____

Relationship to patient _____

Phone _____

Billing Address
(If different from patient address)

Address_____

_____
City State Zip