SPARKS
FAMILY ORTHODONTICS
Laugh Grow Smile

CONFIDENTIAL PATIENT REGISTRATION FORM

Patient's Last Name:________________ First Name:________________ Middle Initial:________

Birthdate: ________________ Gender: Male Female I prefer to be called: ________________

SS#: ____________ Home Phone: ____________ Cell Phone: ____________ E-Mail: ____________

Patient's Address: ____
Street Address City State Zip

Patient is: Single Married Widowed Separated Divorced Spouse's Name *(if married)*: ________________

School *(if a student)*: ____

Occupation *(if applicable)*:____________ Employer: ____________ Business Phone: ____________

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(IF PATIENT IS A MINOR):

Father's Name: ________________ Address: ________________

Father's Employer: ________________ Work Phone: ____________ Cell Phone: ____________

E-Mail: ________________

Mother's Name: ________________ Address: ________________

Mother's Employer: ________________ Work Phone: ____________ Cell Phone: ____________

E-Mail: ________________

Responsible Party for this Account: ________________ *SS#:* ____________

*Responsible Party Address:*____
Street Address City State Zip

Names and Ages of Siblings: ____

Siblings had orthodontic treatment? ________________ Orthodontist: ________________

Have parents had orthodontic treatment? Mother Father Orthodontist: ________________

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GENERAL INFORMATION:

Yes No Patient brushes teeth conscientiously? Yes No Patient follows directions?

Reason for seeking orthodontic treatment? ____

Whom may we thank for referring you? ____

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Do you have orthodontic insurance? *Yes No*

If yes, please complete the insurance authorization enclosed. Thank you.