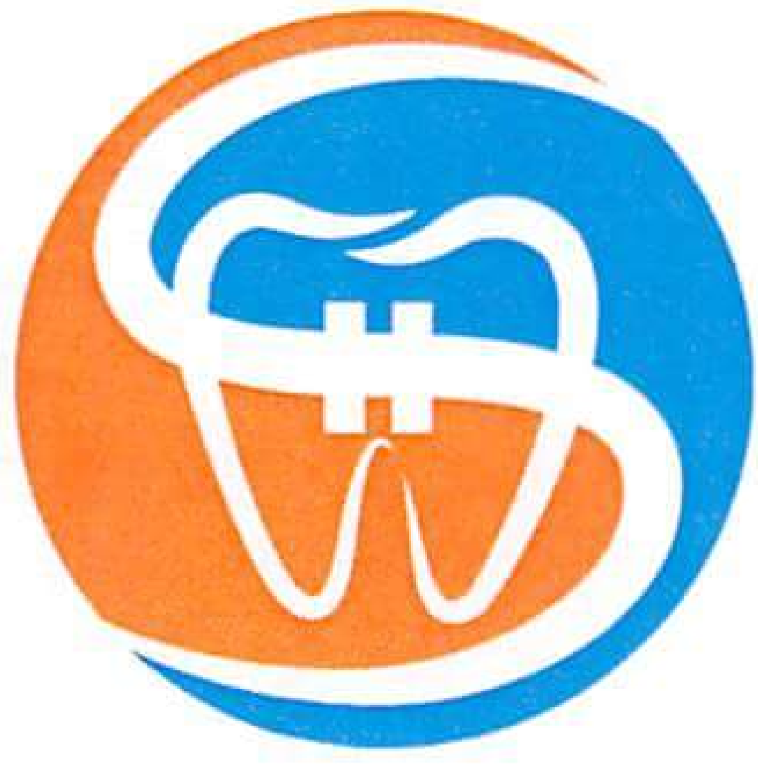

SPARKS
FAMILY ORTHODONTICS
Laugh Grow Smile

CONFIDENTIAL PATIENT REGISTRATION FORM

Patient's First Name: ______________________ Middle Initial: ______ Last Name: ______________________

Name I prefer to be called: ____________________ Gender: Male ☐ Female ☐ Birthdate: ____________________

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

Patient's Address: ____
Mailing Address City State Zip

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

School (*if a student*): ____

Occupation (*if applicable*): ______________ Employer: ____________________ Work Phone #: ______________

****

(IF THE PATIENT IS A MINOR, PLEASE FILL OUT BELOW):

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: ____
Mailing Address City State Zip

Names and Ages of Siblings: ____

Siblings received orthodontic treatment? ______________________________ Orthodontist: ______________

Have parents received orthodontic treatment? Mother ☐ Father ☐ Orthodontist: ______________________

****

Reason for seeking orthodontic treatment? ____

How did you hear about our office? ____

****

*****Do you have orthodontic insurance?*** ***Yes*** ☐ ***No*** ☐

*****If yes, please complete the insurance authorization enclosed. (page 3)***