PATIENT REGISTRATION
HUB CITY ORTHODONTICS
(please print)

Date_____ **Parent e-mail address:**_____

Patient's First Name_____Middle Initial____Last Name_____Home Phone #_____

Mother's or Father's Cell Phone #_____

Patient's Address_____City_____State_____Zip_____

Sex____Age_____Birthdate_____

Father's Name_____Is his address the same as the patient's? Yes_____ No_____

Father's Address (if different from pt.)_____ Phone_____

City_____ State_____ Zip_____

Father's Employer_____Length of Employment_____

Father's Business Phone_____

Mother's Name_____(Miss/Mrs/Ms circle one) Is her address same at the patient's? Yes___No___

Mother's Address (if different from pt.)_____Phone_____

City_____State_____Zip_____

Mother Employer_____Length of Employment_____

Mother's Business Phone_____

Marital Status of Parents: (circle one) Married Single Separated Widowed Divorced

Name of Person Responsbile for Account_____ Relationship to Patient_____

Father's Dental Insurance Company_____Group #_____

Mother's Dental Insurance Company_____ Group #_____

Patient's Dentist_____ **Patient's** Physician_____

Were you referred to our office by another patient? Name:_____

Please understand that, because most of our patients are school children, it may be necessary to have your child taken out of school for some appointments which require more time to perform.

If someone other than a parent or legal guardian consistently brings the patient to our office for appointments, do we have your permission to share any information, including financial, with them? Yes____ No____

I hereby acknowledge that I have read and understand this form and that all the information I have given above is accurate to the best of my knowledge.

Signed_____ **PLEASE COMPLETE HEALTH HISTORY ON THE BACK OF THIS FORM**