# PATIENT REGISTRATION
# HUB CITY ORTHODONTICS
**(please print)**

**Date**______________________ **Patient e-mail address**____________________________

**Patient's** First Name_______________Middle Initial____Last Name______________Home Phone #________________

Cell Phone #_________________

**Patient's** Address_________________________________City____________________State________Zip_________

Sex____ Miss/Mrs/Ms/Mr. (circle one) Age_______Birthdate__________

Patient's Employer_____________________________________ Length of Employment There_____________________

Patient's Business Phone__________________________________

**Spouse's Name**_______________________________

**Spouse's Address** (if different from pt.)____________________________________ Phone______________________

City___________________________________ State________ Zip___________

**Spouse's** Employer_____________________________________________Length of Employment___________________

**Spouse's** Business Phone________________________________________

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

Name of Person Responsbile for Account_________________________ Relationship to Patient______________________

**Patient's** Dental Insurance Company__________________________________________Group #_____________________

**Spouse's** Dental Insurance Company_________________________________________ Group #_____________________

Which of these is the primary dental carrier?______________________________________________________________

**Patient's** Dentist________________________ **Patient's** Physician________________________

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

Please understand that we may have to have you miss work on occasion for appointments which require more time.

Do we have your permission to share any information, including financial, with your spouse? 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**