Renick Orthodontics

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WELCOME

PATIENT INFORMATION(MINOR)

Today's Date:		Birthdate:		Gender:	M F
Last Name:		First Name:		MI:	
Address:					
City:		State:		Zip:	
Home Phone:		Cell Phone:			
Hobbies/pets:					

Today's Visit:

Who is accompanying your child today? (Name)_____

Relationship to patient: _____ Custodial Parent: _____

How did you hear about our office? _____

List any family members in treatment in our office: _____

Reason for your visit?_____

Siblings:

Name	Date of Birth	Age	Gender (M or F)

Parent's Marital Status: (circle one): Married Separated Widowed Divorced Single Partnered

Mother's Information ☐SAME ADDRESS AS PATIENT			
Name:		DOB:	
Address:			
Home #			
Cell #			
Work #		SSN#	
Employer		Yrs?_____	
Occupation			

Father's Information ☐SAME ADDRESS AS PATIENT			
Name:		DOB:	
Address:			
Home #			
Cell #			
Work #		SSN#	
Employer		Yrs?_____	
Occupation			

Step Father's Information/Guardian			
Name:		DOB:	
Address:			
Home #			
Cell #			
Work #		SSN#	
Employer		Yrs?_____	
Occupation			

Step Mother's Information/Guardian			
Name:		DOB:	
Address:			
Home #			
Cell #			
Work #		SSN#	
Employer		Yrs?_____	
Occupation			