Steven M. Lash, D.D.S., M.S., P.C.
Rebecca L. Rubin, D.M.D., M.S.

REGISTRATION

DATE:_____

NAME:_____ NICKNAME:_____ AGE: _____ SEX:_____

ADDRESS:_____ CITY & ZIP:_____ HOME PHONE:_____

SCHOOL:_____ HOBBIES:_____

PARENT #1 FULL NAME (Ms., Mrs., Dr., Mr.):_____

ADDRESS (if different than patient):_____ HOME PHONE:_____

OCCUPATION/ EMPLOYER:_____ WORK PHONE:_____ CELL PHONE:_____

PARENT #2 FULL NAME (Ms., Mrs., Dr., Mr.):_____

ADDRESS (if different than patient):_____ HOME PHONE:_____

OCCUPATION/ EMPLOYER:_____ WORK PHONE:_____ CELL PHONE:_____

OTHER CHILDREN IN FAMILY (Names & Ages):_____

ANY PREVIOUS ORTHODONTIC TREATMENT OR CONSULTATION?_____

WHAT DO YOU WISH ORTHODONTIC TREATMENT TO ACCOMPLISH?_____

NAME OF GENERAL DENTIST:_____ LOCATION:_____

NAME OF DENTAL INSURANCE:_____ ORTHODONTIC COVERAGE: YES NO

SUBSCRIBER NAME: _____ ID #:_____ GROUP #:_____

IF PATIENT IS A MINOR, WHO IS LEGALLY/ FINANCIALLY RESPONSIBLE?_____

WHOM MAY WE THANK FOR REFERING YOUR CHILD?_____

MEDICAL HISTORY

DATE OF BIRTH:_____ DATE AND PURPOSE OF LAST MEDICAL EXAM:_____

HAS PATIENT BEEN HOSPITALIZED IN LAST 5 YEARS?_____ IF YES, DESCRIBE:_____

IS PATIENT CURRENTLY RECEIVING MEDICAL CARE?_____ IF YES, DESCRIBE:_____

IS PATIENT TAKING ANY MEDICATION?_____ IF YES, DESCRIBE MEDICATION/ REASON:_____

IF ALLERGIC TO MEDICATION OR DRUGS, INDICATE WHICH ONES:_____

HAS PATIENT EVER HAD ANY INFECTIOUS DISEASE? _____ IF YES, DESCRIBE:_____

HAS PATIENT EVER BEEN DIAGNOSED AS HAVING TEMPOROMANDIBULAR JOINT DISORDER?_____

ANY PHYSICAL CONDITIONS OR HABITS?_____

NAME OF PHYSICIAN:_____ LOCATION:_____

THIS INFORMATION WAS GIVEN BY:_____

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