Adult Registration Form

Thompson Orthodontics
1450 Columbus Avenue, Suite 101
Washington Court House, OH 43160
740.335.2921

Today's Date: ________________

Patient's Name: ____ Date of Birth: _____________________
(First) (Middle) (Last)

Name you prefer to be called: ______________________________________

Social Security No.: ______________________ Age: ________ Gender: (circle one) Male Female

Patient's Address: ____
(Street) (City) (State) (Zip)

Home Phone: _________________________ Cell Phone: ________________________

Patient's Email: ____

Employed By: _________________________________ Occupation: ____________________________

Work Address: ____
(Street) (City) (State) (Zip)

Spouse's Name: _____________________________ Social Security No. _____________________

Spouse's Home Phone: ______________________ Spouse's Cell Phone: ________________________

Spouse Employed By: ___________________________ Occupation: ____________________________

Emergency Contact: ____ Phone: _____________________

Do you have dental insurance? Yes No Who holds insurance policy? _______________________
If yes, what insurance company? _______________________________ Group No. ___________

Signature: ______________________________ Date: _____________________

Print Name: _____________________________

By signing this form you assume financial responsibility for the Orthodontic exam and related fees