Align Orthodontics

PATIENT HISTORY

In order for this practice to provide the highest standard of care, it is requested you fill in this form carefully and thoroughly.

Surname _____ Other Names _____

Title (e.g. Mst/Miss/Other) _____ Date of Birth _____

Home Address _____

Business Address _____

Phone _____ Mobile _____ BH Phone _____

Email _____

Postal Address (if different from above) _____

Name of person responsible for fees _____

Address (if different from above) _____

Emergency Contact _____ Relationship _____ Phone _____

Address _____

Medical Doctor _____ Phone _____

Address _____

Dentist _____ Phone _____

Address _____

Do you have a health fund? ☐ Yes ☐ No If yes, please list fund _____

Who recommended our practice to you? _____

How did you find us ☐ Google ☐ Facebook ☐ Instagram ☐ Yellow Pages ☐ Other _____

Do any other family members attend our practice? _____

Do you have any hobbies or interest? _____

If applicable, what school do you attend? _____

If applicable, what level? _____

PLEASE NOTE:
On future visits any changes to the above should be advised.

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