Sherman Orthodontics
Great Smiles Start Here

PATIENT'S REGISTRATION FORM

PATIENT INFORMATION

PATIENT'S NAME _____ _____ SEX
(First Name) (Last Name) ☐ M ☐ F

ADDRESS _____ APT NO. _____

CITY _____ POSTAL CODE _____

E-MAIL _____ CELL PHONE (____)_____

HOME PHONE (_____) _____ BUSINESS PHONE (____) _____

DATE OF BIRTH _____ / _____ / _____ AGE _____
(Month) (Day) (Year)

FAMILY DENTIST _____ FAMILY PHYSICIAN _____

WHO MAY WE THANK FOR RECOMMENDING US TO YOU? _____

REASON FOR PRESENTATION/CONCERNS: _____

_____

I hereby give Dr. M. Sherman and/or members of his staff permission to release information concerning my orthodontic and/or dental health to my dentist or any other dentist or dental specialist as is deemed necessary from time to time. Such information includes x-rays and other diagnostic records and pertains to the initial condition, diagnosis, proposed treatment and treatment in progress.

_____ X _____
(Date) (Patient Signature)

_____ X _____
UPDATE 1 (Date) (Patient Signature)

_____ X _____
UPDATE 2 (Date) (Patient Signature)