

# THE ORTHODONTIC PLACE

## Patient Information (Confidential)

Patient's name \_\_\_\_\_ Date \_\_\_\_\_

Preferred pronouns (please select)  She/Her  He/Him  They/Them  Other \_\_\_\_\_

Nickname \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

Suburb \_\_\_\_\_ Postcode \_\_\_\_\_

Sport/Hobbies \_\_\_\_\_

Siblings (name and ages) \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Other family members treated at our office \_\_\_\_\_

## Responsible Party Information

Parent or guardian name \_\_\_\_\_

Mailing address \_\_\_\_\_

Suburb \_\_\_\_\_ Postcode \_\_\_\_\_

Mobile \_\_\_\_\_ Email address \_\_\_\_\_

Occupation \_\_\_\_\_ Partners Name \_\_\_\_\_

Relationship to patient \_\_\_\_\_

## Dental Insurance Information

Private Health Provider \_\_\_\_\_

Orthodontic Cover  Yes  No

## Emergency Information

Emergency Contact Name and Phone Number \_\_\_\_\_

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