PATIENT REGISTRATION FORM

Poulsbo 360.697.3008 | Mailing: P.O. Box 2257, Poulsbo, WA 98370 | Office: 18825 Caldart Ave. NE, Suite A
Bainbridge 206.842.0337 | Mailing: P.O. Box 2257, Poulsbo, WA 98370 | Office: 727 Ericksen Avenue NE, Suite 1
www.linkorthodontics.com

Today's Date _____

CHILD'S INFORMATION

Child's Name _____ Middle Initial _____
Nickname _____
Family E-mail _____
Birthday _____ Gender _____ Age _____
Parent's Marital Status: Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed [ ]
Child Resides With _____

PRIMARY CONTACT INFO

Parent/Guardian Name _____ Relationship to Patient _____
Address _____
City _____ State _____ Zip _____ Social Security # _____
Employer _____ Occupation _____
Phone Numbers H _____ W _____ C _____
Email _____ Birthday _____
How may we contact you? Home Phone [ ] Cell Phone [ ] Work Phone [ ] Email [ ] Text Message [ ]

ALTERNATE CONTACT INFO

Parent/Guardian Name _____ Relationship to Patient _____
Address (If different from above) _____
City _____ State _____ Zip _____ Social Security # _____
Employer _____ Occupation _____
Phone Numbers H _____ W _____ C _____
Email _____ Birthday _____
How may we contact you? Home Phone [ ] Cell Phone [ ] Work Phone [ ] Email [ ] Text Message [ ]

PRIMARY DENTAL INSURANCE

Name of Insurance _____
Name of Subscriber _____ Group # _____ Insured's DOB _____
If different from responsible party, please fill out the information below:
Insured's Social Security # _____ Insured's Phone # _____

SECONDARY DENTAL INSURANCE

Name of Insurance _____
Name of Subscriber _____ Group # _____ Insured's DOB _____
If different from responsible party, please fill out the information below:
Insured's Social Security # _____ Insured's Phone # _____

HOW DID YOU FIND US?

Whom may we thank for referring you? Another Dentist or Doctor [ ] _____
Insurance [ ] _____ Family/Friend [ ] _____ Other [ ] _____