

**Steven M. Lash, D.D.S., M.S., P.C.**  
**Rebecca L. Rubin, D.M.D., M.S.**

**REGISTRATION**

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ NICKNAME: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY & ZIP: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

SCHOOL: \_\_\_\_\_ HOBBIES: \_\_\_\_\_

FATHER'S FULL NAME (Mr., Dr.): \_\_\_\_\_

ADDRESS (if different than patient): \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

OCCUPATION/ EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

MOTHER'S FULL NAME (Ms., Mrs., Dr.): \_\_\_\_\_

ADDRESS (if different than patient): \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

OCCUPATION/ EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

OTHER CHILDREN IN FAMILY (Names & Ages): \_\_\_\_\_

ANY PREVIOUS ORTHODONTIC TREATMENT OR CONSULTATION? \_\_\_\_\_

WHAT DO YOU WISH ORTHODONTIC TREATMENT TO ACCOMPLISH? \_\_\_\_\_

NAME OF GENERAL DENTIST: \_\_\_\_\_ LOCATION: \_\_\_\_\_

NAME OF DENTAL INSURANCE: \_\_\_\_\_ ORTHODONTIC COVERAGE: YES NO

SUBSCRIBER ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

IF PATIENT IS A MINOR, WHO IS LEGALLY/ FINANCIALLY RESPONSIBLE? \_\_\_\_\_

WHOM MAY WE THANK FOR REFERING YOUR CHILD? \_\_\_\_\_

**MEDICAL HISTORY**

DATE OF BIRTH: \_\_\_\_\_ DATE AND PURPOSE OF LAST MEDICAL EXAM: \_\_\_\_\_

HAS PATIENT BEEN HOSPITALIZED IN LAST 5 YEARS? \_\_\_\_\_ IF YES, DESCRIBE: \_\_\_\_\_

IS PATIENT CURRENTLY RECEIVING MEDICAL CARE? \_\_\_\_\_ IF YES, DESCRIBE: \_\_\_\_\_

IS PATIENT TAKING ANY MEDICATION? \_\_\_\_\_ IF YES, DESCRIBE MEDICATION/ REASON: \_\_\_\_\_

IF ALLERGIC TO MEDICATION OR DRUGS, INDICATE WHICH ONES: \_\_\_\_\_

HAS PATIENT EVER HAD ANY INFECTIOUS DISEASE? \_\_\_\_\_ IF YES, DESCRIBE: \_\_\_\_\_

HAS PATIENT EVER BEEN DIAGNOSED AS HAVING TEMPOROMANDIBULAR JOINT DISORDER? \_\_\_\_\_

ANY PHYSICAL CONDITIONS OR HABITS? \_\_\_\_\_

NAME OF PHYSICIAN: \_\_\_\_\_ LOCATION: \_\_\_\_\_

THIS INFORMATION WAS GIVEN BY: \_\_\_\_\_

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