School of Orthodontics
BROOKS REHABILITATION
COLLEGE OF HEALTHCARE SCIENCES

New Patient Telephone: 904-256-7970 **Website: JUSmiles.com**

Patient Form – Adult

Patient's Name: ______________________________________Nickname:___________________ Gender: [ ] M [ ] F
Patient's D.O.B.: ____________________________________ Patient's SS# ___________________________________
Street Address:____Apt./Unit___________
City ____State: ______________ Zip:______________
Home Phone: ( ) ____________________________________Cell Phone: ( ) ____________________________
Patient's Email: ____
Marital Status: _____Single ____Married ____Separated____ Divorced _____ Other
Employer ____ Work Phone ( ) _________________________________

List Name & Contact Information for the person who will be Financially Responsible for Treatment – (if Other than the patient)

Name: _______________________________________
(H) Address ___________________________________
____
Date of Birth__________________________________
Phone (H) ____________________________________
Phone (C) _______________ (W)_________________
Drivers License # ______________________________
Soc. Security # ______________________________
Email ____________________________________
Relationship to Patient _________________________

List Name & Contact Information for the person who carries Orthodontic Insurance for the patient – (if Other than the patient)

Name: _______________________________________
(H) Address ___________________________________
____
Date of Birth__________________________________
Phone (H) ____________________________________
Phone (C) _______________ (W)_________________
Drivers License # ______________________________
Soc. Security # ______________________________
Email ____________________________________
Relationship to Patient _________________________

General Dentist (Name & Phone Number): ____
Have we treated other family members? [ ] Y [ ] N Name of Family Member: __________________________________

If you want to allow us to communicate with anyone about you, please fill out and sign our "PERMISSION TO COMMUNICATE" FORM

I understand that this information is correct, that it will be used for my benefit and that Brooks Rehabilitation College of Healthcare Sciences School of Orthodontics (BRCHS SOO) is relying on its accuracy. I am responsible for providing BRCHS SOO with any necessary information, changes in information, and prompt completion of forms. I understand that in the event that financial obligations cannot be met, BRCHS SOO has the right to terminate treatment on my child regardless of whether or not the treatment objectives have been met.

____ ______________________________
Signature of Patient Date

FOR OFFICE USE ONLY

Comprehensive_______ Simple___________ Invisalign ____________ Lingual___________ Two Phase__________
Recall_______ # of Months _____ No TX _______
Notes____
Faculty ________________________________Resident____

FOR OFFICE USE ONLY

Fee Consult Date____________Completed By_____________Records Date_____________Sched. With_____________