School of Orthodontics
BROOKS REHABILITATION
COLLEGE OF HEALTHCARE SCIENCES

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

Patient Form – Child

Patient's Name: _____Nickname:_____ Gender: [ ] M [ ] F
Patient's D.O.B.: _____ Patient's Age _____
Street Address:_____Apt./Unit_____
City _____State: _____ Zip:_____
Home Phone: ( ) _____
Patient's School: _____Grade: _____

General Dentist (Name and Phone Number): _____
Are we treating other family members? [ ] Y [ ] N Name of Family Member: _____
Parents' marital status: [ ] Married [ ] Divorced [ ] Separated [ ] Other
Who is/are the legal guardian: [ ] Joint [ ] Mother [ ] Father [ ] Other _____
If someone other than the legal guardian will be bringing a child to appointments, please fill out and sign our "PERMISSION TO COMMUNICATE" FORM

Mother's Contact Information

Name: _____
(H) Address _____
_____
Date of Birth_____
Phone (H) _____
Phone (C) _____ (W)_____
Driver's License # _____
Soc. Security # _____
Email _____

Father's Contact Information

Name: _____
(H) Address _____
_____
Date of Birth_____
Phone (H) _____
Phone (C) _____ (W) _____
Driver's License # _____
Soc. Security # _____
Email _____

Please indicate the name of the person who will be Financially Responsible: _____

Other Guardian(s) Contact Information_____

_____

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 Parent/Guardian 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_____