KRiSTAL SMILES

203-212-3200

REGISTRATION FORM

(All of your information is confidential)

Today's Date: _____/_____/_____

Patient's Name: _____

Date of Birth: _____/_____/_____ **Gender:** M / F

Home Address: _____

City: _____ **State:** _____ **Zip**:_____

Cell #: ( ) _____ **Home #:** ( ) _____

Email: _____

* We are committed to keeping your e-mail address confidential. We do not sell, rent, or lease our subscription lists to third parties, and we will not provide your personal information to any third party individual, government agency, or company at any time unless compelled to do so by law. We will use your email strictly for office purposes such as appointment reminders, discounts, newsletters, and activities.

What is the patient's main orthodontic concern?

_____

Whom may we thank for referring you?

_____

Emergency Contact: Name: _____

Relationship: _____

Phone #: ( ) _____

General Dentist Info: Name: _____

Phone #: ( ) _____

Address: _____

_____