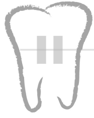

Justin Pagan, DDS, MSD
Orthodontic Specialist

Today's date: __________________

Patient Information

Name: ____ Preferred Name: ___________________________

Gender: ________ Birthday: __________________ Age: ________

Street Address: ____

City/State: _________________________________ Zip: _____________

Home Phone: (______) _______________ Cell Phone: (______) _______________

Medical Alert(s): ____

School: ____ Grade: _________

General Dentist: ____

Street Address: ____ Office Phone: (______) _______________

Who referred you to our office? ______________________________

Have any relatives been a patient here? If so, who? ____

Parent(s)/Guardian(s) Information

Name: ____ Relation to Patient: _______________________

Birthday: __________________

Street Address: ____

City/State: _________________________________ Zip: _____________

Home Phone: (______) _______________ Cell Phone: (______) _______________

Employer: ____ Work Phone: (______) _______________

Name: ____ Relation to Patient: _______________________

Birthday: __________________

Street Address: ____

City/State: _________________________________ Zip: _____________

Home Phone: (______) _______________ Cell Phone: (______) _______________

Employer: ____ Work Phone: (______) _______________

Emergency Contact

Name: ____ Relation: _______________________

Phone: (______) _______________