Paul L. Ouellette, DDS.,M.S., ABO
Orthodontics For Children and Adults
Patient Registration Form

PATIENT PERSONAL INFORMATION: *(To Whom We Provide Dental or Orthodontic Services)*

Circle One Below

Last Name:__________________________ First Name:______________ Mr. Mrs. Ms. Dr.

Address:____________________________ City:_____________ State:_______ Zip:_____________

Telephone: Home#: _______________ Work#: _______________ Cell#: ___________

Date of Birth: ________ Age: ______ Male ______ Female ______ Dentist: _________

Relation to Guarantor: _______________ SELF ___ SPOUSE ___ CHILD ___ OTHER_____

Email Address: ______________________ Fax Telephone #: _____________ SS#: ___________

GUARANTOR INFORMATION: (Person(s) Responsible for Payment for Services) ☐ **Patient is Guarantor**

Leave Blank If Information Is Same As Above ***Circle One Below***

Last Name:__________________________ First Name:______________ Mr. Mrs. Ms. Dr.

Address:____________________________ City:_____________ State:_______ Zip:_____________

Telephone: Home#: _______________ Work#: _______________ Cell#: ___________

Date of Birth: ________ Age: ______ Male ______ Female ______ Dentist: _________

Relation to Patient: _______________ SELF ___ SPOUSE ___ CHILD ___ OTHER_____

Email Address: ______________________ Fax Telephone #: _____________ SS#: ___________

EMPLOYER INFORMATION: (Person(s) Responsible for Payment for Services)

Guarantor Employer:__________________________ Spouse Employer: _________________________

Address:_____________________________________ Address:__________________________________

City:___________________________ State:_______ City:_________________________ State:______

Employer Telephone #: ________________________ Employer Telephone #: _____________________

CONSENT FOR EXAMINATION &/OR TREATMENT: This is to certify that I, the undersigned, consent to the performing of dental, oral surgical, or orthodontic procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated and I will assume responsibility for fees associated with those procedures. I also understand and agree that the responsibility for any treatment rendered me, my spouse, or my child is that of the Doctor who renders that treatment and not that of AffordableBRACES.com, PA. I understand that payments to AffordableBRACES is for purposes of collections made by that dental center in behalf of the Doctor(s) who treats me and I agree that it in no way makes AffordableBRACES.com, PA responsible for any treatment given to me. I agree that any such treatment will be a matter between the treating Doctor and myself. I understand that no Doctor has jurisdiction or authority over any other Doctor and that each Doctor is responsible for his or her own patients and the treatment he or she renders.

Patient,Parent,or Guardian's Signature:____ Date:_________________