

**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 ClearSmilesATLANTA. I understand that payments to ClearSmilesATLANTA 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 ClearSmilesATLANTA 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:** _____