



Timothy B. Elison, DMD, MS

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Specialists in orthodontics for children and adults.

Please Complete the following Patient Registration and Confidential Health History

1 Step

Please Start Here. (Complete all that apply)

Today's Date

Patient Name Sex

Birth Date Age (years & months) Dentist

Street Address

City State Zip Code

Home Phone # Work Phone # Cell Phone #

Name of person supplying information Relationship

Father's Name D.O.B Employer

Address City State Zip

Home # Work # Cell #

Mother's Name D.O.B Employer

Address City State Zip

Home # Work # Cell #

2 Step

Emergency Contact Information

Name of an individual you would like to contact in an emergency?

Relationship

Home # Cell #

Who Referred you to Elison Orthodontics?

3 Step

Insurance Information

Primary

Dental Insurance Company Insurance Phone #

Group Id # Subscriber Id #

Employer

Insured Employee Name Relation to Pt.

Insured Employee SS# D.O.B.

Secondary

Dental Insurance Company Insurance Phone #

Group Id # Subscriber Id #

Employer

Insured Employee Name Relation to Pt.

Insured Employee SS# D.O.B.

4 Step

Person Financially Responsible for Account

Name D.O.B.

Address City State Zip

Home/Cell Phone # Work Phone # Ext #

SS # Driver License #

Employer

Email Address