



Welcome to our office

How did you hear about us? Or whom may we thank for referring you to our office? _____

Have other immediate family members been treated in this office? Yes No

What are your chief concerns?

Appearance of teeth (Crowding, spacing, etc)

Problems with joints (TMJ etc)

Problems with bite (Crossbites, overbites, etc)

Missing, extra or impacted teeth

Other (please list) _____

Patient Information

Patient Name _____ Preferred first name _____ Home phone _____
Last Name First Name

Gender M F Birthdate ____/____/____ Age _____ School _____ Grade _____

Physician _____ Oral Surgeon _____ Dentist _____

Hobbies _____

Names and ages of other children in family _____

Parent (s) with whom patient lives

Father or stepfathers name _____ SSN _____
Last Name First Name

Employer _____ Occupation _____ Years employed _____

Work Phone _____ Cell Phone _____ Birthdate _____

Mother or stepmothers name _____ SSN _____
Last Name First Name

Employer _____ Occupation _____ Years employed _____

Work Phone _____ Cell Phone _____ Birthdate _____

Address _____ Years at this address? _____
Street City State Zip

Person (s) responsible for payment (check all that apply)

Mother Father Stepmother Stepfather Other (specify) _____

Please fill out if a parent not living with patient is to be financially responsible for account

Name _____ SSN _____
Last Name First Name

Address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____ Years Employed _____

Work Phone _____ Home Phone _____ Birthdate ____/____/____

Insurance Information

Do you have orthodontic insurance to assist you with payment? Yes No Do you have dual coverage? Yes No

I hereby authorize Dr, Shepherd's office to obtain a credit report to assist in determining payment plans Yes No

Signature _____ Today's Date ____/____/____