Welcome to our office

Adult form

Whom may we thank for referring you to our office? (Dentist, friend, family, website/internet, etc.) _____

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 overbite etc) ☐ Missing, extra or impacted teeth ☐
Other (please list)_____

Patient Information

Name _____ SSN# _____
Preferred first name (if different from above) _____ Sex _____
Physician _____ Oral Surgeon _____ Dentist _____
Employer _____ Occupation _____ # yrs employed_____
Work phone _____ Cell phone _____ Home phone _____
Email _____ Marital status _____ Birthdate_____

Spouse's Name _____ SSN# _____
Employer _____ Occupation _____ # yrs employed_____
Work phone _____ Cell phone _____ Birthdate_____

Address_____ City _____ State _____ Zip _____
How long at this address?_____

Previous address (if at current address less than 3 yrs)
Address_____ City _____ State _____ Zip _____
How long at this address?_____

Names and ages of children _____
_____
Hobbies_____

Please indicate if you would like an appointment reminder?
None ☐ Text message ☐ Phone number _____

Insurance Information

Do you have orthodontic insurance? 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_____ Date _____