Welcome to our office

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

Patient's Name _____ Home phone _____
Patient's preferred first name (nickname) _____ Sex _____
Birthdate _____ Age _____ School _____ Grade _____
Physician _____ Oral Surgeon _____ Dentist _____
Names and ages of other children in family _____
Hobbies _____

Parent(s) with whom patient lives

Father or stepfathers name _____ SSN _____
Employer _____ Occupation _____ # yrs employed _____
Work phone _____ Cell phone _____ Birthdate _____
Email _____

Mother or stepmothers name _____ SSN _____
Employer _____ Occupation _____ # yrs employed _____
Work phone _____ Cell phone _____ Birthdate _____
Email _____

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

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

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

Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Other (specify) _____

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

Name _____ SSN _____
Address _____ City _____ State _____ Zip _____
Employer _____ Occupation _____ # yrs employed _____
Work phone _____ Home phone _____ Birthdate _____

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 _____