

SHULTS ORTHODONTICS, PLLC

Randall C. Shults DDS, MA, PhD.

Today's Date: ____ - ____ - ____

Name: _____ Preferred Name: _____

D.O.B.: ____ - ____ - ____ Age ____ Male ____ Female ____

Address: _____ APT#: _____

City: _____ State: _____ Zip: _____

Home Phone: ____ - ____ - ____ Mobile: ____ - ____ - ____ Work: ____ - ____ - ____

Employer's Name: _____ Occupation: _____

E-mail Address: _____ SS#: ____ - ____ - ____

Interests & Hobbies: _____

Reason for orthodontic consultation: _____

Patient's Dentist: _____ Date of last dental checkup: ____ - ____ - ____

Whom may we thank for referring you to our office: _____

Additional Comments: _____

I authorize and request diagnostic and dental treatment as found necessary and desirable by Randall C. Shults, DDS, MA, PhD, in connection with orthodontic services for the Patient above. I will accept responsibility for this account, or any part thereof should named responsible party fail or insurance benefits be denied or insufficient to pay the full fee.

SIGNATURE

PRINT NAME

____ - ____ - ____
DATE