

SHULTS ORTHODONTICS, PLLC

Randall C. Shults DDS, MA, PhD.

Today's Date: _____-_____-_____

Patient's Name: _____ Preferred Name: _____

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

Patient's special interests/hobbies: _____

Mother's Name: _____

Address: _____ APT#: _____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____ Mobile: _____-_____-_____ Work: _____-_____-_____

D.O.B. _____-_____-_____ SS# _____-_____-_____

Employer's Name: _____ Occupation: _____

E-mail Address: _____

Father's Name: _____

Address: _____ APT#: _____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____ Mobile: _____-_____-_____ Work: _____-_____-_____

D.O.B. _____-_____-_____ SS# _____-_____-_____

Employer's Name: _____ Occupation: _____

E-mail Address: _____

Patient Lives with: _____

(Name)

(relationship)

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