Dr. M. Jean Kay and Dr. Brent Paulus
Orthodontics

A B C E

Today's Date:				Name by which patient is called:			
Patient Information							
First	Last		Middle Initial	Birth Date: / /		M F	Age:
Street Address:				Social Security #:		Home Phone:	
City:	State:			Zip Code:		Cell Phone:	
Email:				Email Reminder: Yes or No Text Reminder: Yes or No			
Preferred Method of Contact: Home Phone or Cell Phone or Email or Other							
Occupation:		Employer:				Work Phone:	
Patient's Dentist:				Patient's Physician:			
Who may we thank for referring you to our office?							

Responsible Party Information						
First:	Last		Middle Initial	Birth Date: / /		Relationship:
Street Address:				Social Security #:		Home Phone:
City:	State:			Zip Code:		Cell Phone:
Occupation:		Employer:				Work Phone:

- I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my resposibility to inform this office of any changes.
- I authorize the dental staff to perform any necessary dental services during diagnosis and treatment.
- I understand that when fees are presented, Credit Bureau reports are obtained.

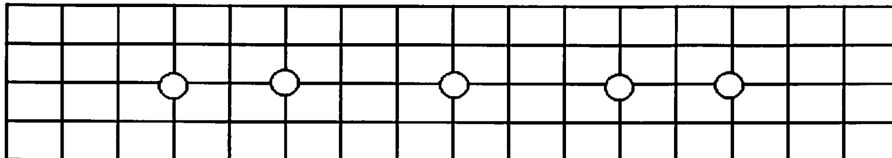
Signature　　　　　　　　　　　　　　　　　　　Date

☐ Please check only if you do not want to apply for interest free in-office payments.

CONTINUED ON THE BACK

Health History	
Do you have any significant physical or medical problems? Allergies?	
Have you had any injury to the face, mouth or teeth? Please describe:	
Did you ever suck a thumb or finger? Until what age?	
Are you under the care of a physician?	Are you taking any medication or need to be pre-medicated?
Has an orthodontist been consulted previously?	Has either parent or sibling had orthodontic treatment?
Are you aware that some appointments may infringe on work and/or school?	

For Office Use Only



1 2 3

Present
Att
Profile
Symmetry
Lip Coverage
Midline
XB
OB
OVB
Slide
Habits
Growth