Dr. M. Jean Kay and Dr. Brent Paulus A B C E

Orthodontics

Today's Date:			Name by which patient is called:		
Patient Information					
First Last		Middle Initial	Birth Date: / /	M F	Age:
Street Address:			School:	Home Phone:	
City:	State:		Zip Code:	Cell Phone:	
Patient's Dentist:			Patient's Physician:		
Who may we thank for referring you to our office?					
Responsible Party Information					
Person Responsible for Account: Relationship:		Address:		Social Security #	
Mother's First: Last		Middle Initial	Birth Date: / /	Marital status: Single / Married / Divorced / Widowed / Separated	
Street Address:			Social Security #:		
City	State:		Zip Code:	Home Phone:	
Email:			Email Reminder: Yes or No Text Reminder: Yes or No	Cell Phone:	
Preferred Method of Contact: Home Phone or Cell Phone or Email or Other:					
Occupation:		Employer:		Work Phone:	
Father's First: Last		Middle Initial	Birth Date: / /	Marital status: Single / Married / Divorced / Widowed / Separated	
Street Address:			Social Security #:		
City:	State:		Zip Code:	Home Phone:	
Email:			Email Reminder: Yes or No Text Reminder: Yes or No	Cell Phone:	
Preferred Method of Contact: Home Phone or Cell Phone or Email or Other:					
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 responsibility 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.

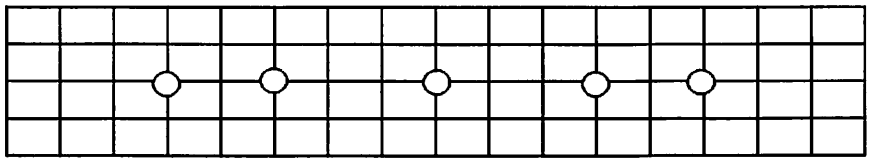
Parent/Guardian Signature _____ Date _____

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

CONTINUED ON THE BACK

Health History	
Does the patient have any significant physical or medical problems? Allergies?	
Has there been any injury to the face, mouth or teeth? Please describe:	
Has the patient ever sucked a thumb or finger? Until what age?	
Is the patient under the care of a physician?	Is the patient taking any medication or need to be pre-medicated?
Has an orthodontist been consulted previously?	Has either parent or sibling had orthodontic treatment?
Names and ages of other children in the family:	
What is your concern about your child's teeth?	
Are you aware that some appointments may infringe on school time or work?	

For Office Use Only



1 2 3

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