Dr. Robert B. Julius and Dr. M. Jean Kay

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:		School:		Home Phone:	
		Apt #:		Cell Phone:	
City:	State:	Zip Code:			
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 #:		
		Apt #:		Home Phone:
City:	State:	Zip Code:		Cell Phone:
Occupation:	Employer:			Work Phone:

Father's First: Last		Middle Initial	Birth Date: / /	Marital status: Single / Married / Divorced / Widowed / Separated
Street Address:		Social Security #:		
		Apt #:		Home Phone:
City:	State:	Zip Code:		Cell Phone:
Occupation:	Employer:			Work Phone:

Insurance Information		
Insurance Co:	Subscriber's Name:	Employer:
Insurance Co:	Subscriber's Name:	Employer:

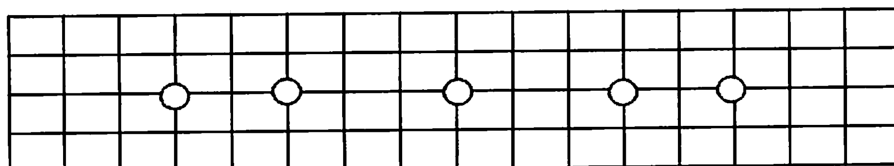
I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I understand that where appropriate, Credit Bureau reports may be obtained. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Patient/Guardian Signature ______________________ Date ______________

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



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

Missing

Extractions Recommended

Extractions Completed

Possible Future Extractions