

**DR. KLINT R. BUTLER**  
**SPECIALIST IN ORTHODONTICS**

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**1. Patient Information**

Last Name \_\_\_\_\_, First Name \_\_\_\_\_, M. I. \_\_\_\_\_  
I prefer to be called: \_\_\_\_\_  
Gender: Male \_\_\_ Female \_\_\_  
Age: \_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Driver's License Number \_\_\_\_\_  
Home Telephone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_  
Home Address: Street: \_\_\_\_\_ Apt. No.: \_\_\_\_\_  
City: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
E-mail address \_\_\_\_\_  
Employer's Name and Address: \_\_\_\_\_  
Work Telephone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Extension: \_\_\_\_\_  
In an emergency whom should we contact? \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Emergency contact's relationship to patient? \_\_\_\_\_  
General Dentist: \_\_\_\_\_ Date of last dental visit: \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
What are the main concerns or problems for orthodontics to correct? \_\_\_\_\_  
\_\_\_\_\_

**2. Person Responsible for Account**

Name: \_\_\_\_\_ SS Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Relationship: \_\_\_\_\_ Driver's License Number: \_\_\_\_\_  
Address if different from yours \_\_\_\_\_  
Telephone number if different from yours: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

**3. Primary Dental and Orthodontic Insurance**

Company: \_\_\_\_\_  
Address: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_  
Policy Group Number: \_\_\_\_\_  
Policy Owner's Name: \_\_\_\_\_  
Policy Owner's Date of Birth: \_\_\_\_\_  
Policy Owner's SS Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Policy Owner's Employer: \_\_\_\_\_

**Secondary Dental and Orthodontic Insurance**

Company: \_\_\_\_\_  
Address: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_  
Policy Group Number: \_\_\_\_\_  
Policy Owner's Name: \_\_\_\_\_  
Policy Owner's Date of Birth: \_\_\_\_\_  
Policy Owner's SS Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Policy Owner's Employer: \_\_\_\_\_

**4. Dental and Medical History**

Physician: \_\_\_\_\_  
Date of last medical visit: \_\_\_\_\_  
Is your current physical health \_\_\_ Good, \_\_\_ Fair, \_\_\_ Poor?  
Medications currently taking: \_\_\_\_\_  
Allergies to medications, metals, latex, plastics or other (specify): \_\_\_\_\_  
Have there been any injuries to the face, mouth and chin? \_\_\_ Yes, \_\_\_ No  
Have you ever been informed of any missing or extra permanent teeth? \_\_\_ Yes, \_\_\_ No  
Do you brush your teeth daily? \_\_\_ Yes, \_\_\_ No  
Do you floss your teeth daily? \_\_\_ Yes, \_\_\_ No

**Please continue completing this form on the reverse side**

Have you ever had any of the following medical problems? If yes please explain below:

- Yes  No Abnormal bleeding  
 Yes  No Anemia  
 Yes  No Artificial Bones/ Joints/ Heart Valves  
 Yes  No Asthma  
 Yes  No Arthritis  
 Yes  No Blood Transfusion  
 Yes  No Cancer  
 Yes  No Chemotherapy/ Radiation (X-Ray) Treatment  
 Yes  No Congenital Heart Defect  
 Yes  No Convulsions/Epilepsy/ Seizures/ Fainting  
 Yes  No Diabetes  
 Yes  No Difficulty Breathing  
 Yes  No Drug/ Alcohol Abuse  
 Yes  No Emphysema  
 Yes  No Handicaps/Disabilities  
 Yes  No Headaches  
 Yes  No Heart Murmur/Attack/Stroke/Surgery/Pacemaker/Valve Defects  
 Yes  No Hemophilia  
 Yes  No Hepatitis  
 Yes  No High/Low Blood Pressure  
 Yes  No HIV+/AIDS  
 Yes  No Kidney/Liver Problems  
 Yes  No Mental Health Care  
 Yes  No Rheumatic/Scarlet Fever  
 Yes  No Sinus Problems  
 Yes  No TMD/TMJ jaw joint problems  
 Yes  No Tuberculosis (TB)  
 Yes  No Ulcers/Colitis  
 Yes  No Venereal Disease  
 Yes  No Viral Infections/ Fever Blisters/ Herpes/Shingles

Please describe any hospital stays, operations or yes answers above.

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Have you had in the past, or presently have any of the following habits?

- Yes  No Clenching/Grinding Teeth  
 Yes  No Lip Sucking/Biting  
 Yes  No Mouth Breathing  
 Yes  No Nail Biting  
 Yes  No Thumb/Finger \_\_\_\_\_ Days \_\_\_\_\_ Nights. If stopped, what age? \_\_\_\_\_  
 Yes  No Tongue Thrust

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status, address, and telephone number. I also give permission to release information to my insurance company(ies) to expedite payment for services, and understand that I am responsible for all fees incurred.

\_\_\_\_\_  
Signature of patient

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

Review of dental/medical information Dr.'s initials \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_