

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

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**1. Child's Information**

Last Name \_\_\_\_\_, First Name \_\_\_\_\_, M. I. \_\_\_\_  
Nickname: \_\_\_\_\_  
Gender: Male \_\_\_\_\_ Female \_\_\_\_\_  
Age: \_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Home Telephone Number: (\_\_\_\_)\_\_\_\_-\_\_\_\_ E-Mail Address: \_\_\_\_\_  
Home Address: Street: \_\_\_\_\_ Apt. No.: \_\_\_\_\_  
City: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
List brothers/sisters with date of birth: \_\_\_\_\_  
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 Accompanying Child**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

**3. Parent's Information**

Mother's Name: \_\_\_\_\_ Employer: \_\_\_\_\_  
E-mail address: \_\_\_\_\_ Driver's License Number \_\_\_\_\_  
Work Number: (\_\_\_\_)\_\_\_\_ Extension: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_  
To file insurance we need date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ and Social Security Number \_\_\_\_/\_\_\_\_/\_\_\_\_

Father's Name: \_\_\_\_\_ Employer: \_\_\_\_\_  
E-mail address: \_\_\_\_\_ Driver's License Number \_\_\_\_\_  
Work Number: (\_\_\_\_)\_\_\_\_ Extension: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_  
To file insurance we need date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ and Social Security Number \_\_\_\_/\_\_\_\_/\_\_\_\_

Who is legal guardian of this child? \_\_\_\_\_  
Parent's marital status: Single \_\_\_\_; Married \_\_\_\_; Widowed \_\_\_\_; Divorced \_\_\_\_; Separated \_\_\_\_

**4. Person Responsible for Account**

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

**5. Primary Dental and Orthodontic Insurance**

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

**Secondary Dental and Orthodontic Insurance**

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

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

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

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

6. Dental and Medical History

Is the child's 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 adenoids or tonsils been removed? Yes \_\_\_\_, No \_\_\_\_

Has puberty begun? Yes \_\_\_\_, No \_\_\_\_

Has menstruation begun (girls)? Yes \_\_\_\_, No \_\_\_\_

Has your child been informed of any missing or extra permanent teeth? Yes \_\_\_\_, No \_\_\_\_

Has your child ever had any jaw joint pain or tenderness (TMJ or TMD)? Yes \_\_\_\_, No \_\_\_\_

Does your child brush his or her teeth daily? Yes \_\_\_\_, No \_\_\_\_

Does your child floss his or her teeth daily? Yes \_\_\_\_, No \_\_\_\_

Child's Physician: \_\_\_\_\_

Date of last medical visit: \_\_\_\_\_

Has your child ever had any of the following medical problems? If yes please explain below:

Yes \_\_\_\_ No \_\_\_\_ Previous Orthodontic Treatment

Yes \_\_\_\_ No \_\_\_\_ Abnormal Bleeding/Hemophilia

Yes \_\_\_\_ No \_\_\_\_ Asthma

Yes \_\_\_\_ No \_\_\_\_ Cancer

Yes \_\_\_\_ No \_\_\_\_ Congenital Heart Defect

Yes \_\_\_\_ No \_\_\_\_ Convulsions/Epilepsy

Yes \_\_\_\_ No \_\_\_\_ Diabetes

Yes \_\_\_\_ No \_\_\_\_ Handicaps/Disabilities

Yes \_\_\_\_ No \_\_\_\_ Heart Murmur

Yes \_\_\_\_ No \_\_\_\_ Hepatitis

Yes \_\_\_\_ No \_\_\_\_ HIV+/AIDS

Yes \_\_\_\_ No \_\_\_\_ Kidney/Liver Problems

Yes \_\_\_\_ No \_\_\_\_ Rheumatic/Scarlet Fever

Yes \_\_\_\_ No \_\_\_\_ Tuberculosis (TB)

Yes \_\_\_\_ No \_\_\_\_ Speech Problems

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

\_\_\_\_\_  
Has your child had in the past, or does he or she 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 not current, stopped 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 confidence, and it is my responsibility to inform this office of any changes in my child's 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. Person(s) offered the Butler Orthodontics Office Fee Plan are subject to a credit check and approval of credit.

\_\_\_\_\_  
Signature of parent(s) or guardian(s)

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

Review of dental/medical information

\_\_\_\_/\_\_\_\_/\_\_\_\_

**Dr.'s initials Date**