

DR. KLINT R. BUTLER
SPECIALIST IN ORTHODONTICS

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1. Adult 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: _____
May we text you appointment reminders? Yes No
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.

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. (There will be a \$25 fee for No Show and less than 24 hr. cancellation notice for appointments.) 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. I understand that Person(s) offered the Butler Orthodontics Office Fee Plan are subject to a credit check and approval of credit (If an interpreter is needed at your appointment, it is your responsibility to have one with you at the time of your appointment.)

_____/_____/_____
Signature of patient Date

Review of dental/medical information Dr.'s initials _____ Date ____/____/____