Paulus
ORTHODONTICS

MICHAEL PAULUS, DDS, MSD
WILLIAM PAULUS, DDS, MS

About Your Child

Today's Date ____/____/____ ☐ Male ☐ Female
Child's Name ______________________
Last First MI
Nickname ______________________
Birth Date ______________ Age ______________
School ______________ Grade ______________
Hobbies/Sports ______________________
Child's Home # (___) ______________________
Child's Home Address ______________________
____
City State Zip

Who is accompanying your child today?

Name ______________ Relation ______________
Parent's marital status ______________________
Do you have legal custody of child? ☐ Yes ☐ No
Whom may we thank for referring you? ______________
Other family members seen by us: ______________
____

General Dentist ______________________
Date of last check-up/cleaning ______________________

☐ Mother ☐ Step Mother ☐ Guardian
Name ______________ Birth Date ______________
Work# ______________ Home (___) ______________
Employer ______________________
Email ______________________
How long at current job? __________ Title ______________
Do you have dental insurance with orthodontic coverage? ___

☐ Father ☐ Step Father ☐ Guardian
Name ______________ Birth Date ______________
Work# ______________ Home (___) ______________
Employer ______________________
How long at current job? __________ Title ______________
Do you have dental insurance with orthodontic coverage? ___

Who will be responsible for making appointments? __________
Who will be responsible for the account? ______________

What are your main goals that you would like orthodontics to accomplish? ______________
____

Has your child ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No
Have there been any injuries to the face, mouth, teeth or chin? ☐ Yes ☐ No
Has your child been informed of any missing or extra permanent teeth? ☐ Yes ☐ No
Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD) ☐ Yes ☐ No
Does your child brush his/her teeth daily? ☐ Yes ☐ No
Floss his/her teeth daily? ☐ Yes ☐ No
Has puberty begun? ☐ Yes ☐ No
Has menstruation begun? (Girls) ☐ Yes ☐ No

Child's physician ______________________
Phone# ______________ Date of last visit ______________
Is your child currently under the care of a physician? ________
Please describe your child's current physical health:
☐ Good ☐ Fair ☐ Poor
Please list all drugs your child is currently taking: __________
____
Please list all drugs/things that your child is allergic to: ______
____

Has your child ever had any of the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Hearing Impairment
Y	N	Allergies to any Drugs	Y	N	Heart Murmur
Y	N	Allergic to Latex/Metals	Y	N	Hemophilia
Y	N	Allergic to Plastic	Y	N	Hepatitis
Y	N	Asthma	Y	N	HIV+/AIDS
Y	N	Cancer	Y	N	Hospitalization
Y	N	Congenital Heart Defects	Y	N	Kidney/Liver Problems
Y	N	Convulsions/Epilepsy	Y	N	Operations
Y	N	Diabetes	Y	N	Rheumatic/Scarlet Fever
Y	N	Handicap/Disabilities	Y	N	Tuberculosis(TB)

Please describe any medical problems that your child has had:
____
____
____

Does/did your child have any of the following habits?

Y	N	Clenching/Grinding	Y	N	Lip Sucking/Biting
Y	N	Nail Biting	Y	N	Tongue Thrust
Y	N	Mouth Breathing	Y	N	Thumb/Finger Sucking
Y	N	Soda Pop Drinker			

I understand that this information is correct and will be held in confidence and it is my responsibility to inform this office of any changes in medical status. I authorize the dental staff to perform the necessary dental services my child may need.

____
Signature of parent or guardian Date

____
Reviewed Date