Thomas W. Butterfoss D.M.D.

Jennifer L. B. Barton D.D.S., M.S.

www.drbutterfoss.com

Tell us about Yourself

1) Name _____ _____
Last First Middle Preferred Name

☐ Male ☐ Female Birth Date: _____ Age: _____

Address: _____ How long at this address: _____

Home Phone: (____)_____ E-Mail: _____

Family in treatment with us: _____

Whom may we thank for referring you? _____

2) General Dentist**:**_____ Last Visit Date**:**_____

Address: _____ Phone **#: (**_____**)** _____

3) **Employer Information**

Employer: _____ Job Title: _____

Work Phone #: **(**_____**)** _____ Cell phone #: **(**_____**)** _____

How long at current job: _____ S.S. #: _____

4) Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

5) Spouse Information

Name: _____ Birth Date: _____

Employer: _____ Work Phone # :**(**_____**)** _____

How long at current job: _____ S.S. #: _____

6) Primary Orthodontic Insurance

Insurance Co. name: _____ Policy Owner's Name: _____

Policy Owner's birth date: _____ Policy Owner's SS #: _____

7) Secondary Orthodontic Insurance

Insurance Co. name: _____ Policy Owner's Name: _____

Policy Owner's birth date: _____ Policy Owner's SS #: _____

I understand that by signing I am giving permission for a credit bureau report to be obtained and reviewed by this office for financing purposes.

Signature: _____ **Date:**_____

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HEALTH HISTORY

Patient Name: _____ ***Date***: _____

Is the patient currently under the care of a physician? ☐ Yes ☐ No
If YES, for what reason? _____

Physician _____ Phone # _____

History of major illness? ☐ Yes ☐ No If YES, Please describe _____

Any sensitivities or allergies? ☐ Yes ☐ No If YES, Please list _____

Currently taking any medications? ☐ Yes ☐ No If YES, Please list _____

Does the patient smoke or use smokeless tobacco? ☐ Yes ☐ No

Has the patient ever had heart trouble? ☐ Yes ☐ No If YES, Please describe _____

Does the patient require antibiotics before dental treatment? ☐ Yes ☐ No

Has the patient ever been treated for any of the following?

☐ Arthritis ☐ Blood disorder ☐ Diabetes ☐ Tuberculosis
☐ Asthma ☐ Blood pressure ☐ Epilepsy ☐ Cancer

Are there any other medical or psychological considerations we should be aware of? ☐ Yes ☐ No
If YES, please explain_____

Dental History

Have there been any injuries to the face, mouth or chin? ☐ Yes ☐ No

Has the patient ever had pain/ tenderness in the jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Does/ Did the patient ever have any of the following habits?

☐ Grinding teeth ☐ Finger/ Thumb sucking ☐ Tongue Thrusting
☐ Mouth Breathing ☐ Chewing/ Eating Problems ☐ Speech Problems

What is your biggest orthodontic concern at present? _____

Patient's attitude towards orthodontics? _____

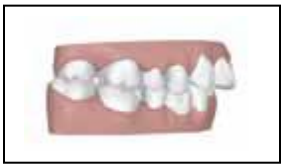
Patient's Hobbies/ Interests: _____

Name: _____

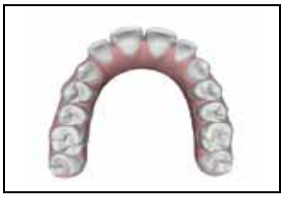
Date: _____

1. **What is your main concern?** (check all that apply)

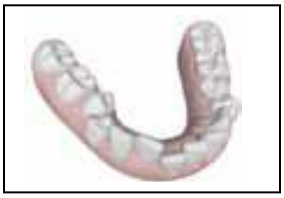
☐ Overjet (Buck teeth)



☐ Spaces between teeth



☐ Crooked/ Crowded teeth



☐ Other (please fill in)

_____

_____

2. What style of treatment would you prefer? (check your preference)

☐ Metal Braces ☐ Ceramic (Clear) Braces ☐ Clear Aligners