Thomas W. Butterfoss D.M.D.

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

www.drbutterfoss.com

1) Child's Name _____ _____
Preferred name

□ Male □ Female Birth Date: _____ Age: _____ Home Ph: (___) _____

School: _____ Grade: _____

Address: _____ How long at this address: _____

Family in treatment with us: _____

*Whom may we thank for referring you?*_____

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

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

□ Mother's Information

3) Name: _____ □ Stepmother □ Other Birthdate: _____

Mailing Address _____ How long at this address: _____

Home Phone #: **(**___**)** _____ Cell #: **(**___**)** _____ Work #: **(**___**)** _____

Employer: _____ Job title:_____ How long at current job:_____

E-Mail address_____ S.S. #: _____

□ Father's Information

4) Name: _____ □ Stepfather □ Other Birthdate: _____

Mailing Address: _____ How long at this address: _____

Home Phone #: **(**___**)** _____ Cell #: **(**___**)** _____ Work #: **(**___**)** _____

Employer: _____ Job title:_____ How long at current job: _____

E-mail address: _____ S.S. #: _____

5) Parent's Marital Status □ Single □ Married □ Widowed □ Divorced □ Separated

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 #: _____

8) Emergency contact Name_____ Relationship_____ # :**(**____**)** _____

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.

A B C

Signature: _____ **(Mother) Date:**_____

Signature: _____ **(Father) 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: _____

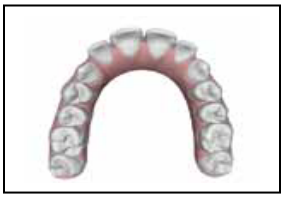
Name: _____

Date: _____

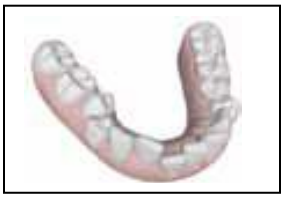
1. **What is your main concern?** (check all that apply)

☐ 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