



☺ **Paul R. Boecler, DMD MS** ☺

Specialist in Orthodontics for Patients of All Ages

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**ADULT PATIENT INFORMATION**

Today's Date	Last Name	First Name	Middle Initial
Name You Prefer To Be Called	Social Security Number - -	Date of Birth / /	Age Sex (Circle) Marital Status (Circle) Male Female S M D W
Home Address	Apt.#	City	State Zip Code
Home Phone	Cell Phone	# to Call for Appointment Confirmation	Email Address
Employer Name	Address	City	State Zip Code
Work Phone	Your Title	How long at current job?	

**Who may we thank for referring you to our office?**

Spouse Last Name	First Name	Middle Initial
Spouse Home Address (if different from above)	Apt.#	City State Zip Code
Spouse Social Security Number - -	Date of Birth / /	Home Phone Cell Phone
Spouse Employer Name	Title	Work Phone How long at current job?

**FINANCIALLY RESPONSIBLE PARTY**

Last Name	First Name	Middle Initial	Billing Phone
Social Security Number - -	Date of Birth / /	Employer	Work Phone How long at current job?
Billing Address	Apt.#	City	State Zip Code

**IN CASE OF EMERGENCY, PLEASE NOTIFY:**

Last Name	First Name	Relationship to Patient	Home Phone	Cell Phone
Home Address	Apt.#	City	State	Zip Code

**DENTAL / ORTHODONTIC INSURANCE**

Primary Insurance Company	Phone #	Secondary Insurance Company	Phone#
Group #	Member #	Group #	Member #
Policy Holder Last Name	First Name	MI	Policy Holder Last Name First Name MI
Social Security # - -	Date of Birth / /	Relationship to Patient	Social Security # - - Date of Birth / / Relationship to Patient
Employer	Employer Phone	Employer	Employer Phone

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**DENTAL / ORTHODONTIC HISTORY**

General Dentist \_\_\_\_\_ Date of Last Visit \_\_\_\_\_ Date of Last Cleaning \_\_\_\_\_

Your current dental health is:  GOOD  FAIR  POOR

**List any concerns you wish to address with orthodontic treatment:**

Have you ever HAD or been EVALUATED for orthodontic treatment before? Y N Do you like your smile? Y N  
Have you ever had any injuries to the face, mouth, teeth or chin? Y N Any problems associated with previous dental work? Y N  
Have you ever experienced pain/discomfort in the jaw joints (TMJ)? Y N Do you brush and floss your teeth daily? Y N  
Do you have any missing or extra permanent teeth? Y N Do your gums ever bleed? Y N  
Do you SMOKE or USE TOBACCO of any kind? Y N Do you breathe through your mouth while asleep? Y N  
Do you breathe through your mouth while awake? Y N

**Have you ever exhibited any of the following? (Please circle Y or N for each)**

Clenching/Grinding Teeth Y N Lip Sucking/Biting Y N Thumb/Finger Sucking Y N  
Tongue Thrust Y N Nail Biting Y N Speech Problems Y N

**MEDICAL HISTORY**

Physician's Name \_\_\_\_\_ Your current physical health is:  GOOD  FAIR  POOR

**Are you currently taking any prescriptions or over-the-counter medications?** Y N

If YES, please list all:

**Are you currently under the care of a physician?** Y N

If YES, please explain:

**\*FOR FEMALE PATIENTS:** Are you currently pregnant? Y N If YES, Number of Weeks: \_\_\_\_\_

**Are you allergic to ANY of the following? (Circle Y or N for each)**

Aspirin? Y N Any Metal or Plastics? Y N Codeine? Y N Dental Anesthetic? Y N Latex? Y N Penicillin? Y N Other? Y N

**Please list all drugs or other materials you are allergic to:**

**Please list all medical conditions you currently have or have ever had:**

**Have you ever had any of the following diseases/medical problems? (Circle Y or N for each)**

Y N Abnormal Bleeding	Y N Difficulty Breathing	Y N Hemophilia	Y N Rheumatic/Scarlet Fever
Y N ADD or ADHD	Y N Drug/Alcohol Abuse	Y N Hepatitis	Y N Severe/Frequent Headaches
Y N Anemia	Y N Emphysema	Y N High/Low Blood Pressure	Y N Shingles
Y N Arthritis	Y N Epilepsy/Seizures/Fainting	Y N HIV+/AIDS	Y N Sickle Cell Disease
Y N Artificial bones/joints/valves	Y N Fever Blisters	Y N Hospitalization	Y N Sinus Problems
Y N Blood Transfusion	Y N Glaucoma	Y N Kidney Problems	Y N Stroke
Y N Cancer/Chemotherapy	Y N Heart Attack	Y N Mitral Valve Prolapse	Y N Tuberculosis(TB)
Y N Congenital Heart Defect	Y N Heart Murmur	Y N Psychiatric Problems	Y N Ulcers (circle Mouth or Stomach)
Y N Diabetes	Y N Heart Surgery/Pacemaker	Y N Radiation Treatment	Y N Venereal Disease (VD)

**Our office is HIPAA compliant and meets/exceeds the standards of infection control mandated by OSHA, CDC & ADA.**

The information I have given is true and correct to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in medical status, insurance coverage and/or contact information. I authorize this office to perform any necessary orthodontic services. This office reserves the right to verify credit status prior to extending credit for treatment fees and may use the services of one or more credit reporting services. I understand that I am responsible for payment of services rendered and for paying any co-payment, deductible or any amount that insurance does not cover. I authorize this office to file insurance claims for orthodontic treatment on my behalf and I authorize insurance benefits be paid directly to Dr. Paul Boecler. I may be charged for missed appointments without a 24-hour cancellation notification. I have received and reviewed a copy of the HIPAA Notice of Privacy Practices.

X \_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_ Date