



**☺ Paul R. Boecler, DMD MS ☺**

Specialist in Orthodontics for Patients of All Ages

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**CHILD / TEEN PATIENT INFORMATON**

Today's Date	Patient's Last Name	First Name	Middle Initial
Name Patient Prefers to be Called	Date of Birth / /	Age	Sex (Circle) Male Female
Patient's Home Address	Apt.#	City	State Zip Code
Patient's Home Phone	# to Call for Appointment Confirmation	Patient's Email Address	
School Name	Grade	Hobbies / Sports	
Name of Person Bringing Patient to Office	Relationship to Patient	Do you have Legal Custody of the Patient? Yes No	

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

FATHER'S INFORMATON				MOTHER'S INFORMATON			
<input type="checkbox"/> <b>Father</b> <input type="checkbox"/> <b>Step Father</b> <input type="checkbox"/> <b>Legal Guardian</b>				<input type="checkbox"/> <b>Mother</b> <input type="checkbox"/> <b>Step Mother</b> <input type="checkbox"/> <b>Legal Guardian</b>			
Father's Last Name	First Name	MI		Mother's Last Name	First Name	MI	
Social Security # - - / /	Date of Birth / /	Home Phone #		Social Security # - - / /	Date of Birth / /	Home Phone #	
Home Address (if different than patient)	City	State	Zip	Home Address (if different than patient)	City	State	Zip
Employer	Employer Phone			Employer	Employer Phone		
How Long at current job?	Your Title			How Long at current job?	Your Title		

**DENTAL / ORTHODONTIC INSURANCE INFORMATION**

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

**FINANCIALLY RESPONSIBLE PARTY**

Last Name	First Name	Middle Initial	Relationship To Patient
Social Security Number - - / /	Date of Birth / /	Employer	Work Phone How long at current job?
Billing Address (if different than patient's)	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

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

**DENTAL / ORTHODONTIC HISTORY**

Patient's General Dentist \_\_\_\_\_ Date of Last Visit \_\_\_\_\_ Date of Last Cleaning \_\_\_\_\_

Patient's dental health is:  GOOD  FAIR  POOR

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

Has patient ever HAD or been EVALUATED for orthodontic treatment before? Y N Does patient like his/her smile? Y N  
Has patient ever had any injuries to the face, mouth, teeth or chin? Y N Any problems associated with previous dental work? Y N  
Has patient ever experienced pain/discomfort in the jaw joints (TMJ)? Y N Does patient brush and floss teeth daily? Y N  
Does patient have any missing or extra permanent teeth? Y N Do patient's gums ever bleed? Y N  
Does patient SMOKE or USE TOBACCO of any kind? Y N Does patient breathe through mouth while asleep? Y N While awake? Y N  
Have adenoids or tonsils been removed? Y N Does patient play any musical instruments? Y N \_\_\_\_\_

**Has patient 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**

Patient's Physician \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Patient's current physical health is:  GOOD  FAIR  POOR Has puberty begun? Y N

**Is patient currently taking any prescription or over-the-counter medications? Y N**

If YES, please list all:

**Is patient currently under the care of a physician? Y N**

If YES, please explain:

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

**Is patient 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 patient is allergic to:**

**Please list all medical conditions patient currently has or has ever had:**

**Has patient 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