



PAULUS ORTHODONTICS

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

About Your Child

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

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

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: _____

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: _____

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

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)

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? _____

Please describe any medical problems that your child has had:

Father Step Father Guardian
 Name _____ Birth Date _____
 Work# _____ Home (____) _____
 Employer _____
 How long at current job? _____ Title _____
 Do you have dental insurance with orthodontic coverage? _____

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	

Who will be responsible for making appointments? _____
 Who will be responsible for the account? _____

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.

There's Magic in Every Smile!

Signature of parent or guardian _____ Date _____
 Reviewed _____ Date _____