ADULT

DATE_____
NAME OF PATIENT_____AGE_____
ADDRESS OF PATIENT_____
CITY_____ZIP_____SS#_____DL#_____
BIRTHDATE_____PHONE #_____ CELL_____
EMAIL_____
PATIENT'S EMPLOYER_____BUS.PHONE_____
BILLING NAME_____BILLING PHONE_____
ADDRESS_____CITY, ZIP_____

SPOUSE'S NAME_____DRIVER'S LIC#_____
EMPLOYER_____BUS.PHONE_____
SS#_____

DENTIST_____ORAL SURGEON_____
PHYSICIAN_____
WHO REFERRED YOU TO DR. PAULUS?_____
DID YOU FIND OUR NAME ON YOUR INS. LIST?_____
DO YOU HAVE INSURANCE THAT COVERS ORTHODONTICS?_____
IF SO, NAME OF INSURANCE CO._____

PRIMARY INSURANCE INFORMATION

DENTAL INSURANCE COMPANY_____
ADDRESS_____
POLICY HOLDER_____POLICY#_____
GROUP#_____SS # OF INSURED_____
INSURANCE PHONE #_____
PLACE OF EMPLOYMENT OF INSURED_____
ADDRESS OF EMPLOYER_____
PHONE # OF EMPLOYER_____

SECONDARY INSURANCE

DENTAL INSURANCE COMPANY_____
ADDRESS_____
POLICY HOLDER_____SS # OF INSURED_____
PHONE # OF INSURANCE COMPANY_____
PLACE OF EMPLOYMENT OF INSURED_____
ADDRESS OF EMPLOYER_____
PHONE # OF EMPLOYER_____

WE APPRECIATE REFFERALS FROM FRIENDS AND FAMILY!

CHILD

DATE_____
NAME OF PATIENT_____PHONE_____
AGE OF PATIENT_____BIRTHDATE_____
ADDRESS OF PATIENT_____
CITY_____ZIP_____SS#_____
EMAIL_____

PERSON RESPONSIBLE FOR PAYING ACCOUNT:
FATHER'S NAME_____DRIVER'S LIC#_____
EMPLOYER_____BUS.PHONE_____
SS#_____ DOB_____

MOTHER'S NAME_____DRIVER'S LIC#_____
EMPLOYER_____BUS.PHONE_____
SS#_____ DOB_____

DENTIST_____ORAL SURGEON_____
PHYSICIAN_____
WHO REFERRED YOU TO DR. PAULUS?_____
DID YOU FIND OUR NAME ON YOUR INS. LIST?_____
DO YOU HAVE INSURANCE THAT COVERS ORTHODONTICS?_____
IF SO, NAME OF INSURANCE CO._____

PRIMARY INSURANCE INFORMATION

DENTAL INSURANCE COMPANY_____
ADDRESS_____
POLICY HOLDER_____POLICY#_____
GROUP#_____SS # OF INSURED_____
INSURANCE PHONE #_____
PLACE OF EMPLOYMENT OF INSURED_____
ADDRESS OF EMPLOYER_____
PHONE # OF EMPLOYER_____

SECONDARY INSURANCE

DENTAL INSURANCE COMPANY_____
ADDRESS_____
POLICY HOLDER_____SS # OF INSURED_____
PHONE # OF INSURANCE COMPANY_____
PLACE OF EMPLOYMENT OF INSURED_____
ADDRESS OF EMPLOYER_____
PHONE # OF EMPLOYER_____

WE APPRECIATE REFFERALS FROM FRIENDS AND FAMILY!

MEDICAL HISTORY

PATIENT_____AGE_____BIRTHDATE_____
SEX_____HT._____WT_____
WHAT IS YOUR REASON FOR SEEKING ORTHODONTIC TREATMENT?
_____

HAS THERE BEEN ANY SERIOUS CHANGE IN YOUR HEALTH WITHIN THE LAST YEAR? IF SO WHAT?
_____
_____

ARE YOU UNDER THE CARE OF A PHYSICIAN? _____
IF YES, WHAT CONDITION(S) IS (ARE) _____
_____

HAVE YOU HAD ANY SERIOUS ILLNESS OR OPERATION? _____
IF SO, DESCRIBE_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

Y____N____ RHEMATIC FEVER
Y____N____ RHEUMATIC HEART DISEASE
Y____N____ CONGENITAL HEART DAMAGE
Y____N____ HEART TROUBLE
Y____N____ ALLERGY
Y____N____ ASTHMA
Y____N____ FAINTING, SEIZURES
Y____N____ AIDS
Y____N____ HEPATITIS
Y____N____ JAUNDICE OR LIVER DISEASE
Y____N____ PAINFULLY SWOLLEN JOINTS
Y____N____ RICKETTS
Y____N____ ENDOCRINE (GLAND TROUBLE)
Y____N____ TUBERCULOSIS
Y____N____ CONVULSIONS
Y____N____ ANEMIA

HAVE YOU HAD ABNORMAL BLEEDING ASSOCIATED WITH PREVIOUS EXTACTION, SURGERY OR TRAUMA? Y____N____
ARE YOU CURRENTLY TAKING ANY MEDICATIONS? Y____N____ IF YES, WHAT? _____
COMMENTS_____
_____

Assignment of Insurance Benefits to Dentist

Office of William G. Paulus, D.D.S., M.S., Inc

I agree to assign benefits from my insurance company to William G. Paulus, D.D.S., M.S., Inc in the course of dental treatment in his office. The treatment and financial plans have been explained and presented to me and the insurance company's portion has been estimated. I understand that after the insurance company has paid their portion to the doctor, the remaining amount (known as the co-payment) is due and payable to William G. Paulus D.D.S., M.S., Inc. I agree to assign benefits to William G. Paulus D.D.S., M.S., Inc from the date of signature below indefinitely.

Method Of Contact

Our office sends Reminder Cards, makes Phone Calls and leaves messages, sends emails and text messages for appointments. Our office will call or fax pharmacy if necessary. Our office will also talk to necessary Doctors and Dentists about your treatment.

Patient Name_____ Date_____

Patient Signature_____ Date_____

Responsible Party Signature_____ Date_____

Dentist Signature_____ Date_____

ACKNOWLDEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature Date

With who may we discuss treatment? _____