Central Texas Orthodontics

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Adult Patient Information

Today's date_____________

Name: ____
(First) (Middle) (Last) MR MRS MS DR

I prefer to be called: ______________________________ ☐ Male ☐ Female

Birth Date: ____/_____/_____ SSN: _______________ Email: __________________________________

Mailing Address: ____
(Street) (City) (State) (Zip)

Home Phone: (___)____________ Cell Phone: (___)_____________ Work Phone: (___)____________

Employer: _____________________________ Occupation:__________________________________

Names and ages of other children in the family: ____
____

Marital Status (Circle one): Single Married Divorced Widow Separated

Spouse's Name: ____ Birthdate:____/_______/_______
Home Phone: (_____)____________________ Cell Phone: (_____)____________________________
SSN: _________________________________ Work Phone: (_____)_____________________________
Employer: _________________________ Occupation: ______________________________________

Responsible Party Information

Name: ____ Birthdate: ______/_______/___________
Mailing Address: ____
(Street) (City) (State) (Zip)
Home Phone:____________________________ Work Phone: _______________________________
Employer:____________________ Occupation:___________________ SSN:____________________

Insurance Information

Policy Holder's Name: _________________________ SSN: _______________DOB: ____/____/_____
Insurance Company: _____________________ Ins. Address _________________________________
Group #: _____________________ I.D. #: _____________ Insurance Phone: __________________
Policy Holder's Employer ____ ____________
Do you have Dual Coverage? ______________? If Yes, please complete section below.

Policy Holder's Name: ___________________________ SSN: ___________ DOB: _____/_____/_____
Insurance Company: _____________________ Ins. Address _________________________________
Group #: _________________ I.D. #: ________________ Insurance Phone ____________________
Policy Holder's Employer ____

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Medical Information

Physician: ____________________________ Phone Number: __________________________________
Office Address: ____
Are you: Presently ill: **Yes No** Under the Care of a physician: **Yes No**
Taking Medication: **Yes No** If yes please list: ____
Allergic to any Medication: **Yes No** If Yes, please list: ___________________________________
Allergic to anything else: **Yes No** if yes, please explain: _________________________________
Has/Had or Have any: (circle all that apply)

Anemia	Chronic Illness	Hospitalization	Heart Disorder
Asthma	Convulsions	Hyperactivity	Heart Trouble
AIDS/HIV	Diabetes	Illness in Infancy	Hepatitis
Bleeding Problems	Emotional Problems	Learning Difficulty	Mental Disorder
Birth Defects	Epilepsy/Seizures	Liver Disease	Milk Allergy
Rheumatic Fever	Speech Impediment	Surgery	Tuberculosis
Tumors/Cancer	Sickle Cell Anemia	Osteoporosis	Arthritis

Please explain any other problems: ____
____
____
____

Dental History

Dentist: ____ Did your dentist refer you? Yes No
Whom may we thank for referring you? ____
Last dental visit: _______________________
Please list what concerns you have about the health and/or appearance of your teeth:
____
Any pervious dental care: Yes No What for: ____
Is there now or has there ever been any of the following: (circle all that apply)

Pain of the TMJ	Oral Habits	Cavities	Toothache	Gum Disease
Extracted Teeth	Injured Teeth	Braces	Unfavorable Experiences	
Thumb Sucking	Lip Biting/ Sucking		Missing or Extra Teeth	

Explain any issues: ____

Permission to Treat

This signature affixed below authorizes examination and treatments, from the office of Dr. Brian St. Louis and Dr. George E. Cantu, and further the use of whatever procedures the judgment of the doctor may deem necessary. Furthermore, the undersigned accepts responsibility of any financial obligation incurred for dental treatment of the patient. I authorize the release of information and assignment of insurance benefits to Dr. Brian St. Louis and Dr. George E. Cantu.

____ (Signature)

_________________ (Date)