Member American Association of **Orthodontists**

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

Orthodontics for Children and Adults

4901 Byers Ave. Fort Worth, TX 76107 Telephone: (817) 738-2163 Fax: (817) 738-9541

CHILD

D.A. W.C.		Cuito			
DATE					
NAME OF PATIENT	PHONE				
AGE OF PATIENT	BIRTHDATE				
ADDRESS OF PATIENT					
CITYZ	.IP	SS#			
EMAIL					
PERSON RESPONSIBLE FOR	PAVING ACC	COUNT			
EMPLOYER	DRIVER'S LIC#				
SS# #	BUS.PHONE DOB				
	DQB				
MOTHER'S NAME		DRIVER'S LIC#			
EMPLOYER		BUS.PHONE			
SS#	DRIVER'S LIC#BUS.PHONEDOB				
DENTIST		ORAL SURGEON			
PHYSICIAN					
WHO REFERRED YOU TO D	R. PAULUS?	LIST?			
DID YOU FIND OUR NAME O	N YOUR INS. L	LIST?			
DO YOU HAVE INSURANCE T	THAT COVERS	S ORTHODONTICS?			
IF SO, NAME OF INSURANCE	CO	1. at 1988			
PRIMARY INSURANCE INFO	<u> PRMATION</u>				
DENTAL DIGUIDANCE COMP	4 3 1 3 7				
DENTAL INSURANCE COMPA	λΝΥ				
ADDRESS					
POLICY HOLDER		POLICY#			
GROUP#	POLICY#SS # OF INSURED				
INSURANCE PHONE #		1			
PLACE OF EMPLOYMENT OF	INSURED				
ADDRESS OF EMPLOYER		·			
PHONE # OF EMPLOYER					
SECONDARY INSURANCE					
SOCOMORKI INSORANCE					
DENTAL INSURANCE COMPA	ANY				
ADDRESS					
POLICY HOLDER		SS # OF INSURED			
PHONE # OF INSURANCE COL	MPANY				
PLACE OF EMPLOYMENT OF	INSURED				
ADDRESS OF EMPLOYED					
PHONE # OF EMPLOYER					
THORE # OF EMPLOTER					

WE APPRECIATE REFFERALS FROM FRIENDS AND FAMILY!

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MEDICAL HISTORY

PATIENT AGE SEX HT. WT WHAT IS YOUR REASON FOR SEEKING	ORTHODONTIC TREATMENT?
HAS THERE BEEN ANY SERIOUS CHANG LAST YEAR? IF SO WHAT?	
ARE YOU UNDER THE CARE OF A PHYS IF YES, WHAT CONDITION(S) IS (ARE)	ICIAN?
ITAVE YOU HAD ANY SERIOUS ILLNESS IF SO, DESCRIBE DO YOU HAVE OR HAVE YOU HAD AN	
YN 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 HAVE YOU HAD ABNORMAL BLEEDING EXTACTION, SURGERY OR TRAUMA? Y ARE YOU CURRENTLY TAKING ANY MI WHAT? COMMENTS	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 G ASSOCIATED WITH PREVIOUS Y N IF YES,

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ADULT'

(3 A T)\$		ADOLI		
DATE			ACE	
NAME OF PATIENT			AGE	
CITY	719			
ADDRESS OF PATIENT	PHONE =			
PATIENT'S EMPLOYER			BUS.PHONE	
BILLING NAME		BILL	NG PHONE	
ADDRESS	BUS.PHONE BILLING PHONE CITY, ZIP			
			·	
SPOUSE'S NAME		D	RIVER'S LICH	
EMPLOYER	DRIVER'S LICHBUS.PHONE			
SS#				
DENTIST		ORAL S	SURGEON	
PHYSICIAN				
WHO REFERRED YOU TO				·
DID YOU FIND OUR NAME	ON YOUR IN	IS. LIST?		
DO YOU HAVE INSURANCE	E THAT COV	ERS ORTHOL	DONTICS?	
IF SO, NAME OF INSURAN	CE CO			
PRIMARY INSURANCE IN	FORMATIO	N		
TRIMANT INSURANCE II	TORNATIO:	<u> </u>		
DENTAL INSURANCE COM	IPANY			
ADDRESSPOLICY HOLDERGROUP#		POLI	CY#	
GROUP#		SS # OF	INSURED	
INSURANCE PHONE #		<u> </u>		
PLACE OF EMPLOYMENT	OF INSURED			
ADDRESS OF EMPLOYER_				
PHONE # OF EMPLOYER_				
SECONDARY INSURANCE	E			
DENTAL INSURANCE CON				
ADDRESS				
POLICY HOLDER		S	S # OF INSURED	
PHONE # OF INSURANCE (COMPANY			
PLACE OF EMPLOYMENT	OF INSURED			
ADDRESS OF EMPLOYER_				
PHONE # OF EMPLOYER_				

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DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

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PATIENT AGE BIRTHDATE SEX HT. WT WHAT IS YOUR REASON FOR SEEKING ORTHODONTIC TREATMENT?						
HAS THERE BEEN ANY SEF LAST YEAR? IF SO WHAT?	RIOUS CHANGE	IN YOUR HEALTH WITHIN THE				
ARE YOU UNDER THE CAR IF YES, WHAT CONDITION(E OF A PHYSICI S) IS (ARE)	[AN?				
HAVE YOU HAD ANY SERIOR SO, DESCRIBE		R OPERATION?				
DO YOU HAVE OR HAVE	YOU HAD ANY O	OF THE FOLLOWING?				
Y N RHEMATIC FEY N RHEUMATIC FEY DISEASE Y N CONGENITAL DAMAGE Y N HEART TROUGHY	HEART HEART	Y N HEPATITIS Y N JAUNDICE OR LIVER DISEASE Y N PAINFULLY SWOLLEN JOINTS Y N RICKETTS Y N ENDOCRINE				
Y N ASTHMA Y N FAINTING, SE Y N AIDS	IZURES	Y N (GLAND TROUBLE) Y N TUBERCULOSIS Y N CONVULSIONS Y N ANEMIA				
EXTACTION, SURGERY OR	TRAUMA? Y_ KING ANY MEDI	ICATIONS? YN IF YES,				