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

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!

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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_____
_____

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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_____
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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_____

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Y___N___ CONGENITAL HEART DAMAGE
Y___N___ HEART TROUBLE
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Y___N___ AIDS

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Y___N___ ENDOCRINE (GLAND TROUBLE)
Y___N___ TUBERCULOSIS
Y___N___ CONVULSIONS
Y___N___ ANEMIA

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