Dr. Steven K. Meier, DDS, MSD
Specialist in Orthodontics

1. **Child's Information**
Last Name_____, First Name_____, M. I.____
Nickname: _____
Gender: Male____ Female____
Age: ____ Birthdate: _____/_____/_____
Home Telephone Number: (_____)_____-_____ E-Mail Address: _____
Home Address: Street: _____Apt. No.: _____
City: _____ Zip Code: _____
List brothers/sisters with date of birth: _____
General Dentist: _____ Date of last dental visit: _____
Whom may we thank for referring you? _____
What are the main concerns or problems for orthodontics to correct? _____
_____

2. **Person Accompanying Child**
Name: _____ Relation: _____

3. **Parent's Information**
Mother's Name: _____Employer: _____
E-mail address: _____Driver's License Number _____
Work Number: (_____)_____ Extension: _____Cell Phone Number: _____
May we text you appointment reminders? Yes ☐ No ☐
To file insurance we need date of birth:____/____/_____ and Social Security Number _____/___/____

Father's Name: _____Employer: _____
E-mail address: _____Driver's License Number _____
Work Number: (_____)_____ Extension: _____Cell Phone Number: _____
To file insurance we need date of birth:____/____/_____ and Social Security Number _____/___/____

Who is legal guardian of this child? _____
Parent's marital status: (Please circle): Single Married Widowed Divorced Separated

4. **Person Responsible for Account**
Name: _____ SS Number: _____--_____--_____
Relation: _____ Driver's License Number: _____
Address if different from child's: _____
Telephone number if different from child's: Home (_____)_____ Work (_____)_____

5. **Primary Dental and Orthodontic Insurance**
Company: _____
Address: _____
_____
Telephone Number: (_____)_____
Group Number: _____
Policy Owner's Name: _____
Policy Owner's Date of Birth: _____
Policy Owner's SS Number: _____-____-_____

Secondary Dental and Orthodontic Insurance
Company: _____
Address: _____
_____
Telephone Number: (_____)_____
Group Number: _____
Policy Owner's Name: _____
Policy Owner's Date of Birth: _____
Policy Owner's SS Number: _____-____-_____

Please continue completing this form on the reverse side

6. **Dental and Medical History**

Is the child's current physical health: Good ____, Fair ____, Poor ____?
Medications currently taking: _____
Allergies to medications, metals, latex, plastics or other (specify): _____
Have there been any injuries to the face, mouth and chin? Yes ____, No ____
Have adenoids or tonsils been removed? Yes ____, No ____
Has puberty begun? Yes ____, No ____
Has menstruation begun (girls)? Yes ____, No ____
Has your child been informed of any missing or extra permanent teeth? Yes ____, No ____
Has your child ever had any jaw joint pain or tenderness (TMJ or TMD)? Yes ____, No ____
Does your child brush his or her teeth daily? Yes ____, No ____
Does your child floss his or her teeth daily? Yes ____, No ____
Child's Physician: _____ _____
Date of last medical visit: _____
Has your child ever had any of the following medical problems? If yes please explain below:

Yes ____ No ____ Previous Orthodontic Treatment
Yes ____ No ____ Abnormal Bleeding/Hemophilia
Yes ____ No ____ Asthma
Yes ____ No ____ Cancer
Yes ____ No ____ Congenital Heart Defect
Yes ____ No ____ Convulsions/Epilepsy
Yes ____ No ____ Diabetes
Yes ____ No ____ Handicaps/Disabilities
Yes ____ No ____ Heart Murmur
Yes ____ No ____ Hepatitis
Yes ____ No ____ HIV+/AIDS
Yes ____ No ____ Kidney/Liver Problems
Yes ____ No ____ Rheumatic/Scarlet Fever
Yes ____ No ____ Tuberculosis (TB)
Yes ____ No ____ Speech Problems

Please describe any additional medical conditions, hospital stays, operations or yes answers above.
_____Has your child had in the past, or does he or she presently have any of the following habits?

Yes ____ No ____ Clenching/Grinding Teeth
Yes ____ No ____ Lip Sucking/Biting
Yes ____ No ____ Mouth Breathing
Yes ____ No ____ Nail Biting
Yes ____ No ____ Thumb/Finger: Days ____, Nights ____ If not current, stopped age ____
Yes ____ No ____ Tongue Thrust

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in confidence, and it is my responsibility to inform this office of any changes in my child's medical status, address, and telephone number. (**There will be a $30 fee for No Show and less than 24 hr. cancellation notice for appointments.)** I also give permission to release information to my insurance company(ies) to expedite payment for services, and understand that I am responsible for all fees incurred. I understand that Person(s) offered the Butler Orthodontics Office Fee Plan are subject to a credit check and approval of credit. The Care Credit Finance Option is offered only on Full Care fee payment (If an interpreter is needed at your appointment, it is your responsibility to have one with you at the time of your appointment.)

_____ ____/____/____
Signature of parent(s) or guardian(s) Date

Review of dental/medical information
_____ ____/____/____
Dr.'s initials Date

530 N. Diers Avenue
Grand Island, NE 68803
(308) 381-8150

4114 4th Avenue
Kearney, NE 68845

www.butlerorthodontics.com