

# Central Texas Orthodontics

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## Child Patient Information

Today's date \_\_\_\_\_

Name: \_\_\_\_\_  
(First) (Middle) (Last) (Nickname)

Mailing Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Home Phone: (\_\_\_\_) \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Referred by: \_\_\_\_\_

Patient's Dentist: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Names and ages of children in family:

\_\_\_\_\_

## Responsible Party Information

Parent's Marital Status (circle one): Single Married Separated Divorced Widow

Father's Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Mailing Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ SSN: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Mailing Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ SSN: \_\_\_\_\_

## Insurance Information

Policy Holder's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Mailing Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Insurance Company: \_\_\_\_\_ Ins. Address: \_\_\_\_\_

Group Number: \_\_\_\_\_ I.D. Number: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_

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

Last dental visit: \_\_\_\_\_

Please list any concerns you have about the health and/or appearance of 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)