



PATIENT INFORMATION

Case # _____
Date _____
Name (& Preferred name) _____ Sex _____ Age _____
Patient's address _____ City _____ Zip _____
Home phone _____ Work phone _____ Birthdate _____
Patient's school district _____ Grade _____ Interest/Hobbies _____

Father's Information

Name _____ Birthdate _____
Address _____ City _____ Zip _____
Home phone _____ Work phone _____ Cell _____
S.S.N. _____ - _____ - _____ Employer _____

Mother's Information

Name _____ Birthdate _____
Address _____ City _____ Zip _____
Home phone _____ Work phone _____ Cell _____
S.S.N. _____ - _____ - _____ Employer _____

Step-Parent's Information

Name _____ Birthdate _____
Address _____ City _____ Zip _____
S.S.N. _____ - _____ - _____ Employer _____

Insurance Information

Do you have dental insurance? _____ Does it cover ortho? _____
Ins. Company _____ Group # _____ Policy # _____
Subscriber (mother or father?) _____
Do you have flex/medical reimbursement plan? _____

Assignment of Benefits

I hereby assign insurance benefits to Dr. J. Todd Hunt
X _____ Date _____
Patient (Employee) or Guardian

Parent's E-mail address: _____

Referral Information

Family Dentist _____
Whom may we thank for recommending our office? _____
Has Dr. Hunt treated others in your family or relatives? _____ Name of family member _____

Medical History

What is the patient's present health? Good _____ Fair _____ Poor _____

Name of Family Physician _____ Date of last visit _____

Circle any of the following that the patient has had (past or present):

- | | | |
|------------------------|-----------------------------|-----------------------------|
| Heart Disease | Liver Problems or Hepatitis | HIV+ or AIDS |
| Artificial heart valve | Kidney problems | Cancer or tumors |
| Heart murmur | Diabetes | Cleft lip/palate |
| Rheumatic fever | Arthritis | Tonsils or Adenoids removed |
| Asthma | Bleeding problems | Speech or hearing problems |
| Epilepsy/Seizures | Others _____ | |

Please list any:

Medications the patient is presently taking: _____

Medications the patient is allergic to: _____

Surgeries or emergency treatment the patient has undergone: _____

Does the patient smoke? Yes _____ No _____

Females: Has menstruation begun: Yes _____ No _____ (This tells us the status of skeletal growth including growth of the jaws)

Is the patient pregnant now? Yes _____ No _____ (For X-ray purposes)

Dental History

What is the patient's present dental health? Good _____ Fair _____ Poor _____

When was the last dental visit? _____

Has the patient ever had any injuries to the jaws, mouth, or teeth?

Yes _____ No _____ If yes, explain _____

Circle any of the following that the patient has had (past or present):

- | | |
|----------------------------|--|
| Toothaches/sensitive teeth | Grinds or clenches teeth |
| Cavities | Jaw joint or muscle pain |
| Bleeding gums | Frequent headaches |
| Thumbsucking | Mouthbreathing or difficulty breathing thru nose |

What is your main reason for seeking this appointment? _____

Signature of Parent or Legal Guardian

Date