HUNT & FALTER
ORTHODONTICS

Confidential Adult Patient Information Date_____

Name:_____Sex:_____Age:_____
Address:_____City:_____State:____Zip____
How long at this address:_____ Own:_____ Rent:_____
Cell Phone:_____Work phone _____
Has Dr. Hunt treated others in your family?_____Name of family member_____
Email _____
Employer:_____Occupation:_____
No. Years Employed_____
SSN#_____-_____-_____ Birthdate_____

Spouse's Information (if applicable)
Name_____
Employer:_____Occupation:_____Yrs Employed_____
SSN#_____Birthdate_____
Cell Phone_____

Dental Insurance Information
Policy Holder's Name:_____ ID or SSN#_____
Insurance Company:_____Group#_____
Insurance Co.Address:_____Ins. Phone #_____
Do you have dual insurance coverage? Yes:_____ No:_____
Policy Holder's Name:_____ ID or SSN #_____
Insurance Company:_____Group# _____
Insurance Company Address:_____
Insurance Phone #:_____

I hereby assign insurance benefits to Dr. J. Todd Hunt PLC
X:_____ Date:_____

Signature of Patient

Medical History

What is your present health? Good____ Fair_____ Poor_____

Name of Family Physician?_____Date of last visit?_____

Circle any of the following that you have had (past or present)

Heart Disease	Liver problems	Hepatitis	HIV/AIDS
Artificial Heart Valve	Kidney problems	Cancer or Tumors	
Heart Murmur	Diabetes	Cleft lip/palate	
Rheumatic Fever	Arthritis	Tonsils or Adenoids removed	
Asthma	Bleeding Disorder	Speech or Hearing problems	
Epilepsy/Seizures	Other:_____		

Please List Any:

Medications you're taking:_____

Medications you're allergic to:_____

Surgeries or Emergency Treatment you have undergone:_____

Latex Allergy: Yes or NO

Do you smoke? Yes____No____

Females:

Are you pregnant now? Yes_____ No_____

(Information for x-rays purposes only)

Dental History

Family Dentist:_____

Who may we thank for referring you?_____

Have you ever had any injuries to the jaw, mouth or teeth?

If yes, explain:_____

Circle any of the following that you have had (past or present)

Toothaches	Sensitivity
Cavities	Jaw joint or muscle pain
Bleeding gums	Frequent headaches
Thumbsucking	Mouth breathing/difficulty breathing through nose

What is the main reason for seeking treatment?_____