



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?** _____