

Confidential Adult Patient Information	Date	
Name:	Sex:	Age:
Address:		
How long at this address: Own:		
Cell Phone:		
Has Dr. Hunt treated others in your family?_		
Email		
Employer:		
No. Years Employed		
SSN# Birthdate		
Spouse's Information (if applicable)		
Name		
Employer:Occup	ation:Y	rs Employed
SSN#Birthdate		
Cell Phone		
Dental Insurance Information		
Policy Holder's Name:	ID or SS	SN#
Insurance Company:		
Insurance Co.Address:		
Do you have dual insurance coverage? Yes:		
Policy Holder's Name:	ID or SSN	V #
Insurance Company:		
Insurance Company Address:		
Insurance Phone #:		
I hereby assign insurance benefits to Dr. J. T	odd Hunt PLC	
X:	Date:	

Signature of Patient

Medical History			
What is your present health? G	ood Fair	Poor	
Name of Family Physician?		Date of last visit?	
Circle any of the following that	t 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 Othe	r:		
Please List Any: Medications you're taking:			
Medications you're allergic to:			
Surgeries or Emergency Treatme	ent you have undergo	ne:	
Latex Allergy: Yes or NO			
Do you smoke? YesNo	-		
E an alon			
Females:	No		
Are you pregnant now? Yes			
(Information for x-rays pu	irposes omy)		
Dental History			
Family Dentist:			
Who may we thank for referri			
Have you ever had any injuries t	o the jaw, mouth or to	eeth?	
If yes, explain:			
Circle any of the following that	-	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	
reatment?	