HUNT & FALTER
ORTHODONTICS

Confidential Patient Information Date_____

Name:_____ Sex:_____Age:_____

Patient's Address:_____ City:_____

State:_____ Zip_____ Primary Phone:_____

Date of Birth:_____Cell phone Provider _____

Patient's School District:_____ Grade:_____

Interest/Hobbies:_____

Has Hunt Orthodontics treated others in your family?_____

Name of family member:_____

Confidential Responsible Party Information

Name:_____ Phone #:_____Marital Status:_____

Address:_____ City:_____ State:___ Zip:_____

How long at this address:_____ Own:_____ Rent:_____

Email Address:_____

Employer:_____ Occupation:_____ # of Yrs Employed:____

SSN #:_____-____-_____Date of Birth:_____Relationship to Patient:_____

Other Legal Guardian

Name:_____Phone #:_____ Marital Status:_____

Address:_____ City:_____ State:___ Zip:_____

Email Address:_____

Employer:_____ Occupation:_____ # of Yrs Employed:____

SSN #:_____-_____-_____ Date of Birth:_____Relationship to Patient:_____

Dental Insurance Information

Policy Holder's Name:_____ ID or SSN #_____

Date of Birth:_____ Relationship to Patient:_____ Primary Phone_____

Policy Holder's Address:_____

Insurance Company:_____ Group #:_____

Insurance Company Address:_____

Insurance Phone #:_____ Policy Holder's Employer:_____

Do you have dual insurance coverage? Yes:_____ No:_____

Policy Holder's Name:_____ ID or SSN #_____

Insurance Company:_____ Group #:_____

Insurance Company Address:_____

Insurance Phone #:_____ Policy Holder's Employer:_____

I hereby assign insurance benefits to Hunt Orthodontics
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	Others:_____		

Please List Any:
Medications:_____
Allergies: Latex Y or N
Surgeries or Emergency
Treatment:_____

Females:
Has menstruation begun? Yes_____ No_____
(Information for status of skeletal, including growth of jaw)
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?
Yes____ No____ 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?_____