MARK S. HUNTER, D.M.D.
ORTHODONTIST
ADULT ORTHODONTIC PATIENT INFORMATION AND HEALTH HISTORY

Welcome to our office. Please fill out **both** sides of form and bring to our office at your first visit. DATE_____

PLEASE PRINT

Patient's Name_____ Age____Birthdate _____ Sex _____

Home Address_____Home Phone_____
STREET CITY ZIP CODE

Employer _____Business Phone_____

Cell Phone_____ E-mail Address_____

Emergency Contact_____Emergency Phone_____

How we may contact you: (Please circle all that apply) Phone / E-mail / Traditional mail

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Person(s) responsible for financial matters

Name(s)_____Relationship_____ _____ Relationship_____

Address same as patient ☐ as below:

Address _____ _____
City, State _____ _____
Phone (Residence)_____ _____
Phone (Business)_____ _____
Place of Employment_____ _____
Social Security Number_____ _____

Is patient covered by insurance for orthodontic/dental treatment? Who has coverage: Self ☐ Spouse ☐ Other ☐

If yes, by which insurance company?_____
Insurance ID and Birthdate of Subscriber(s)_____

Family Dentist	**Family Physician**	**Referred By**
Name _____	_____	_____
Address _____	_____	_____
City, State_____	_____	_____

Family History

Marital status of patient_____
Spouse's Name_____ Occupation:_____

Medical History

Has the patient ever had:

AIDS	Cold Sores	Heart Condition	Lung Disease
Allergy	Diabetes	Head or Face Injury	Oral Ulcer
Anemia	Endocrine Problems	Hepatitis	Previous Surgery
Arthritis	Emotional Problems	Herpes	Rheumatic Fever
Asthma	Epilespsy/Seizures	HIV +	Thyroid Problems
Bleeding	Hearing Problems	Kidney Disease	Other(describe below)

Comments:_____
_____
_____

Has the patient been under the care of a physician during the past two years, other than for routine examination? No Yes
Condition:_____
_____

Does the patient require premedication for dental procedures? No Yes

Present drugs or medication:_____

Birth Defects:_____

Respiratory History

Does the patient:

1. have allergies to: Seasonal grasses_____ Food_____
   Drugs_____ Other_____

2.	breathe through mouth?	Seldom	Sometimes	Usually
3.	snore when sleeping?	No	Yes	
4.	have frequent colds?	No	Yes	
5.	have frequent "stuffy nose"?	No	Yes	
6.	have frequent sore throat or tonsillitis?	No	Yes	
7.	have chewing or swallowing difficulty?	No	Yes	

Has the patient received medical treatment from allergist or ear, nose, and throat specialist? No Yes
If yes: When_____ By Whom_____
Nasal Surgery_____Tonsils Removed_____Adenoids Removed_____

Dental and Temporomandibular Joint History

Has the patient had any unusual dental experiences? No Yes
Specify:_____

Date of last dental check-up_____ Were the patient's teeth cleaned? No Yes

Has the patient ever been treated for T.M.J. ("Jaw Joint") problems No Yes

Does the patient have:

1.	difficulty in mouth opening?	No	Yes
2.	pain or clicking in jaw joint?	No	Yes
3.	pain on chewing, yawning, or wide opening?	No	Yes
4.	pain in or about the ears or cheeks?	No	Yes
5.	a bite that feels "uncomfortable" or "unusual"?	No	Yes
6.	a jaw that "locks", "gets stuck", or "goes out"?	No	Yes
7.	noises in or from the jaw joints?	No	Yes

The following habits are of interest. List information as it pertains to this patient:

1.	Thumbsucking/lipsucking until_____age	No	Yes
2.	Grinding or clenching of teeth	No	Yes
3.	Tongue thrusting or other functional problem	No	Yes

Has the patient had previous orthodontic consultation? No Yes or treatment? No Yes
Date:_____Dr._____

Why did patient seek this consultation?_____

What is the primary problem?_____
_____

What is expected from orthodontic treatment?_____
_____

Additional comments you wish to make?_____
_____

Signature of individual completing this form:_____Today's Date:_____