MARK S. HUNTER, D.M.D.
ORTHODONTIST
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**_____**Birth date** _____ **Sex** _____

Home Address_____ **Home Phone**_____
STREET CITY ZIP CODE

Employer/School_____**Business Phone**_____

Cell Phone_____ **Cell Phone**_____ **E-mail Address**_____
(OF PARENTS, IF MINOR)

Emergency Contact_____ **Emergency Phone**_____

PERSON(S) RESPONSIBLE FOR FINANCIAL MATTERS

Name_____**Relationship**_____ **Name** _____ **Relationship**_____
Address same as patient ____ or as below:

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

Is patient covered by insurance for orthodontic treatment? Who has coverage: **Father** ☐ **Mother** ☐ **Other** ☐
If yes, by which insurance company? _____
Birthdate of Subscriber(s)_____
Social Security Number of Subscriber(s)_____

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

FAMILY HISTORY

Father's Name_____**Living? Yes No** **Occupation**_____
Mother's Name_____**Living? Yes No** **Occupation**_____
Siblings (name and age) _____
Siblings treated at this office (name) _____
Marital status of patient_____**of parents (if minor)**_____
Patient Living with: **Mother** **Father** **Spouse** **Self** **Other:**_____

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	**Epilepsy/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:_____

Has the patient reached puberty (menstruation, hair)? No Yes (This information is needed for growth purposes)

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_____

Relationship to patient_____ Today's Date: _____