HUNTER ORTHODONTICS

Orthodontic Specialist for Children & Adults

Smiles with Style!

Welcome!

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you.

PATIENT INFORMATION

Date: _____ 20 ____

Name: _____
First Name Middle Name Last Name

Address: _____ Home Phone ( ) _____
Street City Zip

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient employed by _____ Occupation _____

Business Address _____ Business Phone ( ) _____

Patient's Dentist _____ Phone ( ) _____ Physician _____ Phone ( ) _____

Whom may we thank for referring you? _____

Person to contact in case of emergency E-mail _____

Name: _____ Phone ( ) _____ Relationship to patient: _____

FINANCIAL INFORMATION

Person Responsible for Account _____
First Name Middle Name Last Name

Relation of Patient _____ Birthdate ___-___-___ Soc. Sec. # _____

Address (if different from patient's) _____

_____ Phone ( ) _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone ( ) _____

Do you have Orthodontic Insurance Coverage? _____

Insurance Company _____ Address _____ Phone ( ) _____

Group # _____ Policy # _____ Subscriber # _____

Signature for release of benefits to doctor _____

INFORMED CONSENT FOR CREDIT CHECKS: This office reserves the right to verify credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more reporting services.
I hereby certify that I have read and agree to this disclosure and give my permission to authorize such a check.

Responsible party sign here: _____ Date: ____/____/____

MEDICAL HISTORY

Is patient in good health? ☐ Yes ☐ No Does patient have any history of major illness? ☐ Yes ☐ No

Has the patient ever been under the care of a physician for illness? ☐ Yes ☐ No Please list: _____

Circle any of the following for which the patient has been treated: Diabetes AIDS Bone Disorders Nervous Disorders Herpes Asthma Anemia Epilepsy Headaches Tuberculosis Liver Involvement Heart Trouble Prolonged Bleeding Autoimmune Disorder Tumors (Cancer) Earaches (Soreness, Ringing Around Ears) Rheumatic Fever Kidney Involvement Fainting or Dizziness Arthritis or Rheumatism Drug Addiction or Alcoholism High (or Low) Blood Pressure

Have tonsils and adenoids been removed? ☐ Yes ☐ No At what age? _____

List any drugs or medication now being taken. Give reasons: _____

_____

Is patient taking any Bisphosphonate medication? ☐ Yes ☐ No **IF YES PLEASE INFORM DR.**

List any allergies or drug/latex sensitivity: _____

PLEASE COMPLETE BOTH SIDES