Welcome

ABOUT THE PATIENT

Patient's Last Name (Please Print) First Middle Initial	Name Patient prefers to be called:	Sex (M or F)	Exam Date / /
Home Address: Street City State Zip Code		Home Phone Number	
Patient's Age	Patient's Birthdate / /	Best Phone Number for this office to use (Please Check box) ☐ Home _____ ☐ Cell _____ ☐ Work _____	

THIS SECTION IS FOR PATIENTS UNDER 18 YEARS OF AGE - PARENT OR GUARDIAN PLEASE COMPLETE

Marital Status of Mother and Father ❑ Married ❑ Divorced ❑ Separated	Who is accompanying the patient today?	
Father's Name ❑ Mr. ❑ Dr.	Father's Employer	Work Phone #
Mother's Name ❑ Mrs. ❑ Ms. ❑ Dr.	Mother's Employer	Work Phone #
Patient's Activities (please list any hobbies, sports or musical instruments played)	School	Grade

Name of Brothers and/or Sisters Age	Name Age	Name Age

ADULT PATIENTS - PLEASE COMPLETE THIS SECTION

Employer	Work Address	Work Phone #
Marital Status ❑ Single ❑ Married	If Married, Name of Spouse	
Spouse's Employer		Spouse's Work Phone #

PERSON RESPONSIBLE FOR THE ACCOUNT

Last Name (Please Print)	First ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr.	Middle Initial	Relationship to Patient
Billing Address: Street City State Zip Code			Home Phone #
Employer	Work Address	Work Phone #	

ORTHODONTIC INSURANCE (PRIMARY)

Insurance Company's Name	ID #		Insurance Company's Phone #
Subscriber's Name	Subscriber's Birthdate / /	Subscriber's Social Security Number	Subscriber's Employer
Subscriber's Relationship to Patient	Subscriber's Address		

ORTHODONTIC INSURANCE (SECONDARY)

Insurance Company's Name	ID #		Insurance Company's Phone #
Subscriber's Name	Subscriber's Birthdate / /	Subscriber's Social Security Number	Subscriber's Employer
Subscriber's Relationship to Patient	Subscriber's Address		

EMAIL ADDRESS	CELL PHONE NUMBER
Parent or Adult Patient	Parent or Adult Patient

HOW DID YOU HEAR ABOUT HUTTO ORTHODONTICS?

DID SOMEONE REFER YOU TO OUR OFFICE? PLEASE GIVE US THEIR NAME.

Name	Address

OTHER FAMILY MEMBERS TREATED BY HUTTO ORTHODONTICS

MEDICAL HISTORY

Has the patient had any of the medical problems listed? PLEASE explain any Yes answers

Yes	No		
❑	❑	High blood pressure?	
❑	❑	Heart problems?	
❑	❑	Bleeding problems?	
❑	❑	HIV/AIDS?	
❑	❑	Hepatitis?	
❑	❑	Any allergies?	
❑	❑	Drug allergies?	
❑	❑	Latex Allergy?	
❑	❑	Artificial joints?	
❑	❑	Handicaps or disabilities?	
❑	❑	Is the patient taking any medication? **PLEASE LIST ALL.**	
❑	❑	Has the patient ever taken medication for osteoporosis or been treated for osteoporosis?	
❑	❑	Has the patient ever been treated for cancer?	

Patient's Dentist is:	Date of Last Dental Cleaning / /

Yes	No		
❑	❑	Does the patient need antibiotics before dental cleanings or visits?	
❑	❑	Is there any dental work in progress?	
❑	❑	Has the patient experienced any "gum tissue" problems? Bleeding?	
❑	❑	Habits such as clenching, grinding, nail biting, tongue thrust, mouth-breathing, or thumb-sucking? (circle those that apply)	
❑	❑	Jaw joint problems - TMJ?	
❑	❑	Has the patient ever been evaluated by an orthodontist?	
❑	❑	Has the patient ever had orthodontic treatment?	

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my/my child's medical status. I authorize the dental staff to perform any necessary dental services that I/my child may need during diagnosis and treatment. I also authorize the orthodontist to share patient's treatment information with collaborating dentists and surgeons when appropriate. I authorize the orthodontist to submit treatment information pertinent to this patient to the insurance company for billing purposes.

Signature of Responsible Party _____ Date _____

Signature of Orthodontist _____ Date _____

Date	Procedure