DAVID C. HUFHAM DMD, PC
ORTHODONTICS *for* children & adults

PATIENT DENTAL HISTORY

Please check appropriate boxes

Y	N	
❑	❑	Do your gums bleed while brushing or flossing?
❑	❑	Are your teeth sensitive to hot or cold liquids/foods?
❑	❑	Are your teeth sensitive to sweet or sour liquids/foods?
❑	❑	Are any of your teeth painful?
❑	❑	Do you have any sores or lumps in or near your mouth?
❑	❑	Do you have frequent headaches/facial pain?
❑	❑	Do you clench or grind your teeth?
❑	❑	Do you like your smile?

Please check if you have ever experienced any of these problems with your jaw:

❑ Clicking ❑ Pain (Joint, Ear, Side or Face) ❑ Difficulty in opening or closing
❑ Difficulty in chewing ❑ Previous TMJ Treatment

Y	N	
❑	❑	Any injuries to face, mouth, teeth or jaw? (circle)
❑	❑	Thumb, finger or lip sucking (circle)
❑	❑	More than average amount of decay?
❑	❑	Any missing permanent teeth?
❑	❑	Any extra permanent teeth?
❑	❑	Any teeth removed by extraction?
❑	❑	Any difficulty in swallowing or chewing?
❑	❑	Have you had previous orthodontic treatment?

Who? _____ When? _____

Patient's attitude toward treatment: (circle one)

Very Motivated Will Cooperate if Needed Not Motivated

On items checked "Yes," please provide us with a more detailed description:	Do you have any dental work that needs to be completed?

PATIENT MEDICAL HISTORY

Please check appropriate boxes

Y	N	
❑	❑	Heart murmur
❑	❑	Mitral valve prolapse
❑	❑	Heart disease/disorder
❑	❑	High blood pressure
❑	❑	Low blood pressure
❑	❑	Bone disorders
❑	❑	Joint replacement or implant
❑	❑	Anemia/Blood disorders
❑	❑	Prolonged bleeding
❑	❑	Rheumatic fever
❑	❑	Arthritis

Y	N	
❑	❑	Immune system problems
❑	❑	Recent weight gain or loss
❑	❑	HIV/Aids
❑	❑	STD
❑	❑	Hepatitis or liver disease
❑	❑	Kidney disease
❑	❑	Diabetes
❑	❑	Tumors/Growths
❑	❑	Cancer treatment
❑	❑	Tonsils or adenoids removed
❑	❑	Tonsillitis

Y	N	
❑	❑	Earaches
❑	❑	Sinus trouble
❑	❑	Asthma/Hay fever
❑	❑	Respiratory problems
❑	❑	Thyroid/Parathyroid problems
❑	❑	Brain injury
❑	❑	Seizures
❑	❑	Fainting/Dizziness
❑	❑	Emotional problems
❑	❑	Psychiatric care
❑	❑	Glaucoma

Are you allergic to or have you had any reactions to the following?

Y	N	
❑	❑	Local anesthetics (e.g. novacain)
❑	❑	Penicillin or other antibiotics
❑	❑	Sulfa drugs
❑	❑	Any metals (e.g. nickel, mercury, etc.)
❑	❑	Latex rubber
❑	❑	Other (please list below)

List any other serious illnesses:

On items checked "Yes," please provide us with a more detailed description:

List any drugs or medications now being taken:	Is patient presently under a physicians care? Reason:
Have you ever been told to pre-medicate before dental appointments? ❑ Yes ❑ No Why?	Name of physician: Phone:

AUTHORIZATION AND RELEASE

I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I 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 medical status.

I hereby authorize the release of all medical records on the above named patient to the referring dentist, physician or other health care provider, as well as information and records necessary for processing insurance claims.

I authorize the necessary diagnostic tests to be performed by or under the direction of Dr. Hufham. I give my permission for any photographs, x-rays or study models to be updated during treatment and used for displays at scientific meetings, presentations and publications of a scientific nature or for study group purposes to further the art and science of orthodontics. I hereby authorize the necessary credit information to be obtained.

We are sorry that we cannot accept divorce decrees as assignments of responsibility for a child's orthodontic bills. The parent accompanying the child should pay for the services and seek any reimbursement from the other parent. I, the undersigned, agree that should collection action become necessary, I agree to pay all cost of collection including all attorney fees and other costs of collection in the event it becomes necessary to use attorney services to secure payment of this account. I agree and waive the right to claim personal property exempt under the laws of the state of Alabama.

Signature _____ Relationship to Patient _____ Date _____

Welcome

DAVID C. HUFHAM DMD, PC
ORTHODONTICS *for* children & adults
120 EUCLID AVENUE [BIRMINGHAM, AL 35213] 205.871.8881

Date _____

PATIENT INFORMATION

Name _____ Nickname _____ D.O.B. _____ Age ____ Sex ____
Address _____ City _____ State _____ Zip _____
Home # _____ Work # _____ Cell # _____ Email _____
School (if a student) _____ Grade _____ S.S. Number _____
Referred by _____ Name of General Dentist _____ Date of Last Cleaning _____
What is the primary concern of the patient's smile? _____
Names and ages of brothers and sisters _____

PARENT INFORMATION

Father's Name _____ S.S. Number _____ D.O.B. _____
Address _____ City _____ State _____ Zip _____
Home # _____ Work # _____ Cell # _____ Email _____
Employer _____ Occupation _____

Mother's Name _____ S.S. Number _____ D.O.B. _____
Address _____ City _____ State _____ Zip _____
Home # _____ Work # _____ Cell # _____ Email _____
Employer _____ Occupation _____

INFORMATION ABOUT PERSON RESPONSIBLE FOR THIS ACCOUNT

Name _____ Relationship to Patient _____
Address _____ City _____ State _____ Zip _____
Driver's License # _____ D.O.B. _____ Spouse's Name _____
Home # _____ Work # _____ Cell # _____ S.S. Number _____
Email _____ Employer _____ Occupation _____

ORTHODONTIC INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____
DOB _____ I.D. Number _____ Date Employed _____
Name of Employer _____ Work # _____
Address _____ City _____ State _____ Zip _____
Insurance Co. _____ Group # _____ Insurance Co. Phone # _____
Insurance Co. Address _____ City _____ State _____ Zip _____

DO YOU HAVE ADDITIONAL ORTHODONTIC INSURANCE? ❑ NO ❑ YES IF YES, PLEASE COMPLETE THE FOLLOWING

Name of Insured _____ Relation to Patient _____
D.O.B. _____ I.D. Number _____ Date Employed _____
Name of Employer _____ Work # _____
Address _____ City _____ State _____ Zip _____
Insurance Co. _____ Group # _____ Insurance Co. Phone # _____
Insurance Co. Address _____ City _____ State _____ Zip _____