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 ________

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 to pay for attorney fees and other costs of collection in the event it becomes necessary to use attorney services to secure payment of this account.

Signature ______________________________ Relationship to Patient ____________________ Date ________