RALEIGH FAMILY
ORTHODONTICS

Hunter Neill DMD

Thank you for selecting our dental healthcare team. We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us, we will be happy to help you.

Date _____

PATIENT INFORMATION (CONFIDENTIAL) Patient SSN# _____

Name _____ Birth date_____ Home Phone _____

Address_____Cell Phone_____

City _____ State_____ Zip _____

Father's Name _____ Email_____

Address _____ Cell Phone _____

City _____ State _____ Zip _____

Father's Employer _____ Work Phone _____

Mother's Name _____Email_____

Address _____ Cell Phone _____

City _____ State _____ Zip _____

Mother's Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Dentist's Name _____

Person to contact in case of emergency _____

RESPONSIBLE PARTY

Name of person responsible for this account _____

Relationship to patient _____

Address_____

Home Phone _____ Soc. Sec. # _____

Employer _____ Work Phone _____

INSURANCE INFORMATION

Name of Insured _____

Relationship to patient_____

Birth date _____ Soc. Sec. # _____

Name of Employer _____Work Phone _____

Insurance Company _____ Ins. Phone _____

PATIENT MEDICAL HISTORY	YES	NO
1. Are you in good health ?	____	____
2. Have you been hospitalized in the past five years?	____	____
3. Are you under medical treatment now?	____	____
4. Are you taking any medications?	____	____

If yes, what medications are you taking? _____

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

Penicillin	____	____
Sulfa	____	____
Codeine	____	____
Latex	____	____
Gloves	____	____

Other allergy _____

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	YES	NO
6. For Adolescent girls only:		
a) Has menstrual period started?	____	____
If yes, when?_____	____	____
7. Have you been advised by a physician to take antibiotics for dental procedures due to a heart murmur?	____	____
8. Do you have any reason to believe that you are HIV positive or at risk of being HIV positive?	____	____

9. Do you have or have you had any of the following?

	YES	NO		YES	NO
Heart Problems	____	____	Hay Fever	____	____
Heart Murmur	____	____	Rheumatic Fever	____	____
Fainting / Seizures	____	____	Diabetes	____	____
Epilepsy / Convulsions	____	____	Kidney Disease	____	____
Hepatitis	____	____	Liver Disease	____	____
Respiratory Problems	____	____	Sickle Cell Anemia	____	____
Bleeding Problems	____	____	Tuberculosis	____	____
Sexually Transmitted Disease	____	____	Cancer	____	____
Low Blood Pressure	____	____	Asthma	____	____
High Blood Pressure	____	____			

PATIENT DENTAL HISTORY	YES	NO
1. Have you had orthodontic work done?	____	____
If yes, when? _____		
2. Do your gums bleed while brushing or flossing?	____	____
3. Have you had any head, neck, or jaw injuries?	____	____
4. Do you clench or grind your teeth?	____	____
5. Have you ever experienced any of the following problems with your jaws?		
a) Clicking	____	____
b) Pain (joint, ear, side of face)	____	____
c) Difficulty in opening or closing	____	____
d) Difficulty chewing	____	____

Authorization and Release

I certify that I have read and understood the above questions and have answered them accurately to theknowledge. I understand that providing incorrect medical information can be dangerous to my health. I authorize the orthodontist to release any information and records pertaining to my diagnosis and treatment to third party payers and/or other health practitioners. I authorize and request my insurance company to pay insurance benefits directly to the orthodontist (unless otherwise indicated). I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf.

X_____

Signature of patient or parent if minor

Doctor's Comments: _____

_____

Signature _____ Date _____

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