Date ______________________

David J. Huyser, D.D.S., M.S.
Orthodontist

CONFIDENTIAL PATIENT INFORMATION

Patient ______________________ Nickname ______________

Age _____ Birthdate __________ Sex _____ Soc. Sec. # ______________ Home Phone __________

Home Address/Street ______________________ City __________ Zip __________

School (if student) ______________________ Class Year __________

Employer ______________________ Office Ph __________

Insurance Carrier ______________ Plan Name __________ Group # __________

Spouse's Name ______________ Employer __________ Office Ph __________

Insurance Carrier ______________ Plan Name __________ Group # __________

Dentist's Name ______________ Address ______________

Physician's Name ______________ Address ______________

Has patient had orthodontic treatment? __________ if so, by whom ______________

What is your main concern in seeking this appointment? ______________________

Who referred you to our office? ______________________

Musical instruments played? ______________________

Are you under the care of a physician? [ ] yes [ ] no

If so, what is the condition being treated? ______________________

Has there been any change in your health in the last year? [ ] yes [ ] no

Have you had any injury to the face, teeth, or jaws? [ ] yes [ ] no

Date of last physical exam? ______________ Immunized? [ ] yes [ ] no

Have you had any serious illness or operation? [ ] yes [ ] no

If so, what was the illness or operation? ______________________

Are you presently taking any medication (prescription or over the counter)? [ ] yes [ ] no

If so, what and for what condition? ______________________

Have you ever had a reaction to any medication? [ ] yes [ ] no

If so, what medication and describe the reaction? ______________________

Females: Are you pregnant? [ ] yes [ ] no

Have you ever had any serious problem associated with any previous dental treatment? [ ] yes [ ] no

If so, explain ______________________

Have you ever had any of the following diseases or problems?

Check all that apply:

[ ] Congenital Heart Disease
[ ] Hepatitis, Jaundice, Liver Disease
[ ] Tonsils Removed
[ ] Cardiovascular Disease
[ ] Convulsions/Seizures
[ ] Mental Illness
[ ] Bleeding Disorders
[ ] Anemia
[ ] Allergy
[ ] Pacemaker/Cardiac Valves
[ ] Arthritis
[ ] Radiation Treatment/Chemotherapy
[ ] Kidney or Urinary Disorders
[ ] Sore Throats/Sinus Problems
[ ] Asthma or Hay Fever
[ ] Heart Murmur
[ ] Diabetes
[ ] Learning Disability
[ ] Respiratory Disease
[ ] HIV/Aids
[ ] Rheumatic Fever
[ ] Tuberculosis
[ ] Speech/Hearing Problems
[ ] Digestive Disorders
[ ] Venereal Disease
[ ] Cleft Lip/Palate

Do you have any disease, condition, or problem not listed above that you think I should know about? [ ] yes [ ] no

If so, explain ______________________

Remarks:

____
Signature/Date