

**Dr. Geri Hunter**  
**Portsmouth Pediatric Dentistry and Orthodontics**

ADULT

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We would like to welcome you to our office. Our goal is to make your visit pleasant and educational.  
Please complete out the information below.

Date: \_\_\_\_\_

**PERSONAL INFORMATION**

NAME \_\_\_\_\_ I prefer to be called: \_\_\_\_\_  
Mr / Mrs / Ms / Dr      First                      MI                      Last

Male     Female      Date of Birth: \_\_\_\_\_      Age: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

General Dentist: \_\_\_\_\_ Date of last cleaning \_\_\_\_\_ Date of last Full Mouth X-rays \_\_\_\_\_

Pending dental work: \_\_\_\_\_

What are your chief orthodontic concerns? \_\_\_\_\_

Have you ever been evaluated for, or previously had, orthodontic treatment? \_\_\_\_\_

Have you ever been seen by or referred to a periodontist? \_\_\_\_\_ Name of periodontist: \_\_\_\_\_

Date last seen by a periodontist : \_\_\_\_\_

Have you ever had periodontal surgery (gum graft, bone graft, deep cleaning, implants etc.)? \_\_\_\_\_

**Who may we thank for referring you to our office?** \_\_\_\_\_

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**FAMILY FACTS**

SPOUSE'S NAME \_\_\_\_\_ Prefers to be called: \_\_\_\_\_  
Mr / Mrs / Ms / Dr      First                      MI                      Last

Sons (with ages): \_\_\_\_\_

Daughters (with ages): \_\_\_\_\_

Have any family members received orthodontic treatment? \_\_\_\_\_ Please name: \_\_\_\_\_

Have any relatives been treated in our office? \_\_\_\_\_ Please name: \_\_\_\_\_

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## Dental Insurance

Name of Insured: \_\_\_\_\_ Insured Social Security #: \_\_\_\_\_

Insured's DOB: \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_

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## Medical History:

Physician: \_\_\_\_\_ Date of last exam: \_\_\_\_\_

Do you have a heart condition which requires you to take antibiotics prior to dental treatment? YES  NO

Circle any of the following medical issues, which apply to your child:

Allergies	Hepatitis	Clenching/grinding teeth
Arthritis	HIV+/AIDS	Clicking/popping of jaw
Asthma	Jaundice	Jaw joint pain (TMJ)
Bleeding disorder	Migraines	Locking of jaw
Cancer	Pregnancy	Lip sucking/biting
Cold sores	Psychological issues	Mouth breather
Convulsions/epilepsy	Rheumatic fever	Nail biting
Diabetes	Sinus trouble	Snoring
Heart murmur	Tuberculosis (TB)	Speech problems
Heart disease	Venereal disease	Thumb sucking habit
		Tongue thrust

Have there been any injuries to the face, mouth, teeth or chin? If yes, describe injury and indicate age when occurred. \_\_\_\_\_

Have you ever worn a nighttime flexible mouthguard or rigid splint? \_\_\_\_\_

Please list any medications you are currently taking and reason for taking. \_\_\_\_\_

Are you allergic to any drugs, latex, or metals? If yes, please specify. \_\_\_\_\_

Please provide additional information on any above circled medical issues or any other conditions we should be aware of.

\_\_\_\_\_  
\_\_\_\_\_

**I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in my medical/dental status or personal information.**

\_\_\_\_\_  
Signature