Dr. Geri Hunter
Portsmouth Pediatric Dentistry and Orthodontics

ADULT

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? _____ _____

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: _____

Dental Insurance

Name of Insured: _____ Insured Social Security #: _____

Insured's DOB: _____ Employer: _____

Insurance Company: _____ Group # : _____

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