THE ORTHODONTIST

TIMOTHY E. HUGHES, D.M.D
312 Mills Avenue Greenville, SC 29605
864-233-3829

Date _____

Patient's Legal Name _____
Last First Middle Nickname

Address _____
Street City State Zip

Birthdate _____ Social Security # _____ Home Phone _____

Employer _____ Work Phone_____ _____

Cell Phone _____ Email Address _____

Marital Status _____ Whom may I thank for referring you? _____

Spouse's Name_____
Last First Middle Nickname

Cell Phone _____ Email Address _____

Employer _____ Work Phone_____ _____

DENTAL OR ORTHODONTIC INSURANCE INFORMATION (ONLY)

Insured's Name _____ Insured's Social Security No._____

Insured's Employer _____Insured's Birthday _____ Insured's Zip Code _____

Name of Insurance Company _____Phone _____

Insurance Company's Address _____
Street City State Zip

Insured's Name _____ Insured's Social Security No._____

Insured's Employer _____Insured's Birthday _____ Insured's Zip Code _____

Name of Insurance Company _____Phone _____

Insurance Company's Address _____
Street City State Zip

EMERGENCY INFORMATION

Name of Nearest Relative
Not Living with You _____
Last First Middle

Address_____
Street City State Zip

Relationship To Patient _____Phone _____

I hereby certify that the information above is true and accurate.

Signature (Parent's signature if minor) _____ Date _____

FEMALE PATIENTS: PLEASE TELL ASSISTANT IF YOU ARE PREGNANT, OR IF YOU THINK YOU MAY BE PREGNANT!
DO NOT ALLOW ANYONE TO TAKE X-RAYS IF POSSIBLY PREGNANT!!!

ADULT PATIENT QUESTIONNAIRE

Nickname or name you like to be called _____Sex _____Birthdate _____

MEDICAL HISTORY

Name of Family Physician _____ Last visit to this Doctor was _____

MD Specialist you see regularly _____ Specialty _____

Under Medical Treatment Now? Yes _____ No _____ For What? _____

Taking Medications Now? Yes _____ No _____ For What? _____

List Medications _____

HISTORY OF:		**EXPLANATION:**
Heart Disease or Diabetes	Yes _____ No _____	_____
Cancer or Skin Cancer	Yes _____ No _____	_____
High Blood Pressure	Yes _____ No _____	_____
Allergies or Asthma	Yes _____ No _____	_____
Hepatitis	Yes _____ No _____	_____
Positive HIV	Yes _____ No _____	_____
Bleeding Disorder or Epilepsy	Yes _____ No _____	_____
Kidney or Liver Disease	Yes _____ No _____	_____
Reaction to Anesthetic	Yes _____ No _____	_____
Reaction to Antibiotics	Yes _____ No _____	_____

DENTAL HISTORY

Name of Family Dentist _____ Last visit to this Dentist was _____

How many times a day do you brush? _____ How many times a day do you floss? _____

Have you Ever Had:

Injury to teeth	Yes _____ No _____	Injury _____What Age?_____
Injury to face	Yes _____ No _____	Injury _____What Age?_____
Stammer or lisp	Yes _____ No _____	What age?_____
Mouth Breathing	Yes _____ No _____	What age?_____
Severe Headaches	Yes _____ No _____	Describe_____
Jaw Joint Pain	Yes _____ No _____	Describe_____
Thumb or Finger Sucking	Yes _____ No _____	Describe_____
Did parents have braces	Yes _____ No _____	Mother _____ Father _____ Both _____
Did any siblings have braces	Yes _____ No _____	

Previous Dental Treatment:

Endodontic (root canal) Tx Yes _____ No _____ Orthodontic (braces) Tx Yes _____ No _____

Oral Surgery (jaw surgery) Tx Yes _____ No _____ Periodontal (gums) Tx Yes _____ No _____

Orthodontic problems or previous Treatment: _____

_____

LATEX ALLERGY: YES _____ NO _____