Hull & Coleman
ORTHODONTICS

Excellent Results from Expert Orthodontists

James C. Hull, DDS, MS Grant G. Coleman, DMD, MS J. Turner Hull, DDS, MS

PATIENT ACQUAINTANCE FORM

Date:_____

Patient's Name _____ _____ _____ _____
Last First Middle Sex (M / F)

Address _____ _____ _____ _____
Street City State Zip

Home Phone _____ Birthdate _____ Age_____ SS# _____

If patient is a minor, please give parent's or guardian's name:_____

Whom may we thank for referring you to our office: _____

Has any member of your family or a friend been seen previously in this practice?_____

Who is your general dentist? _____What school do you attend?_____

RESPONSIBLE PARTY INFORMATION

Name_____ _____ _____ Marital Status _____
Last First Middle

Residence _____ _____ _____ _____
Street City State Zip

Mailing Address _____ _____ _____ _____
Street City State Zip

How long at this address_____Home Phone_____ Work Phone_____

Previous Address (if less than 3 years)_____ _____ _____ _____
Street City State Zip

Email address (to send you appointment reminders and to let you access your account): _____

Social Security #_____ Birthdate _____Relationship to patient _____

Employer_____ Occupation_____ No. Years Employed_____

Spouse's Name_____ _____ _____ Social Security #_____Birthdate_____
Last First Middle

Spouse's Employer_____Occupation_____ Work Phone_____

Does patient (if child) live with both parents? Yes _____ No _____
(If Divorced)
Other Parent's Name_____ _____ _____ Employer_____
Last First Middle

Other Parent's Address_____ Phone_____

Do you have orthodontic insurance? Yes_____ No_____

EMERGENCY INFORMATION

Name of nearest relative not living with you_____Phone_____

Address _____

I agree that all of the above information is correct. I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's if minor)_____

7800 Providence Road, Suite 201, Charlotte, NC 28226 (704) 334-7203
5941 Weddington-Monroe Road, Suite 103, Wesley Chapel, NC 28104 (704) 684-8080

Patient:_____ **Date:**____/____/____

Medical History **Patient's Physician:**_____

- Are you in good health? Yes ☐ No ☐ Explain:_____
- Do you have any history of major illness or hospitalization? Yes ☐ No ☐ Explain:_____
- Are you currently under the care of a physician? Yes ☐ No ☐ Explain:_____
- Do you currently take any medications? Yes ☐ No ☐ List & explain:_____
- Are you allergic/sensitive to any medications? Yes ☐ No ☐ List & explain:_____
- Have your tonsils and adenoids been removed? Yes ☐ No ☐ When?_____
- Did you have a blood transfusion prior to March 1985? Yes ☐ No ☐
  -If Yes, have you tested POSITIVE for HIV/AIDS or hepatitis since then? Yes ☐ No ☐

- Do you currently have or have you ever had any of the conditions listed below? Please check the appropriate response:

Yes	No		Yes	No		Yes	No	
☐	☐	Heart Attack	☐	☐	Anemia	☐	☐	Tuberculosis
☐	☐	Heart Murmur	☐	☐	Bleeding Disorders	☐	☐	Asthma
☐	☐	Rheumatic Fever	☐	☐	Hepatitis	☐	☐	Herpes
☐	☐	Rheumatic Heart Disease	☐	☐	HIV/AIDS	☐	☐	Kidney Disorders
☐	☐	Congenital Heart Defect	☐	☐	Diabetes	☐	☐	Epilepsy
☐	☐	Stroke	☐	☐	Leukemia	☐	☐	Fainting/Dizzy Spells
☐	☐	Mononucleosis	☐	☐	Bone Disorders	☐	☐	Endocrine Disorders
☐	☐	Are you currently under a doctor's orders to take antibiotics prior to dental treatment?						

****

Children/Teens Only

- Has either parent had orthodontic treatment? Yes ☐ No ☐ Explain:_____
- Has the patient reached puberty? Yes ☐ No ☐

****

Dental History **Patient's Dentist:**_____

Patient's Oral Surgeon:_____

- When was your last dental exam/cleaning?_____
- Do you have any missing teeth? Yes ☐ No ☐
  - -extra teeth? Yes ☐ No ☐
  - -loose teeth? Yes ☐ No ☐
  - -sensitive teeth? Yes ☐ No ☐
- Have you ever had any injuries to your face, mouth, or teeth? Yes ☐ No ☐ Explain:_____
- Do you currently suck your thumb or fingers? Yes ☐ No ☐ Explain:_____
- Do you have any speech problems? Yes ☐ No ☐ Explain:_____
- Are you a mouth-breather while awake? Yes ☐ No ☐
  - -while asleep? Yes ☐ No ☐
- Do you have any clicking, popping, or pain in your jaw joint (TMJ)? Yes ☐ No ☐ Explain:_____
- Do you clench or grind your teeth? Yes ☐ No ☐
- Do you suffer frequent headaches? Yes ☐ No ☐
- Does your jaw ever hurt? Yes ☐ No ☐ Explain:_____
- Have you ever had an orthodontic evaluation before today? Yes ☐ No ☐
  - -When?_____
  - -May we ask who you saw?_____

- **In your own words, please tell us why you are interested in orthodontic treatment:**_____

The information given about my health history in this form is accurate and complete to the best of my knowledge. I hereby give my consent to perform necessary diagnostic tests, including x-rays, and to evaluate my dental health.

Signature of patient, parent, or guardian:_____ **Date:**____/____/____

7800 Providence Road, Suite 201, Charlotte, NC 28226 (704) 334-7203
5941 Weddington-Monroe Road, Suite 103, Wesley Chapel, NC 28104 (704) 684-8080