# WELCOME TO DR. HUDGINS' OFFICE

Patient's full name_____ Preferred name_____ (circle one) Male / Female Date_____

Address_____City _____ State_____ Zip _____

Telephone _____ Cell Phone_____Birth date _____ Age_____

**If Patient is an Adult:**
Work Phone_____ Employer_____ E-mail address_____

Social Security #_____ Insurance Company Name_____ID#_____ **(Copy of card is needed)**

**If patient is a Child:**
School _____ Grade _____ Hobbies _____

Patient lives with _____ ( or custodial parent is _____)

Who may we thank for referring you to our office_____

## RESPONSIBLE PARTY INFORMATION (MOTHER or Guardian)

Name _____Relationship to patient if not mother_____

Address _____City _____Zip_____Telephone_____

E-mail address_____Employer_____ Work Phone_____

Social Security #_____ Date of Birth_____

Insurance Company Name _____ID#_____ **(Copy of card is needed)**

## RESPONSIBLE PARTY INFORMATION (FATHER)

Name _____Relationship to patient if not Father_____

Address _____City _____Zip_____Telephone_____

E-mail address_____Employer_____ Work Phone_____

Social Security #_____ Date of Birth_____

Insurance Company Name _____ID#_____ **(Copy of card is needed)**

## PATIENT'S DENTAL & GENERAL HEALTH

Purpose for this visit _____Your Dentist name_____

Date of your last dental check-up? _____Have you ever been evaluated or had orthodontic treatment before? _____

Have any other family members been examined by Dr. Hudgins? If yes, who?_____

In case of emergency, closest relative or friend other than listed here_____Phone:_____
**YES☐NO☐** Do you have allergies? If yes, Type_____Medication_____

**YES☐NO☐** Do you breath through your mouth, or snore when you sleep? Have your tonsils or adenoids been removed? _____

**YES☐NO☐** Have you ever tested positive for HIV, or ever been diagnosed with hepatitis? _____ Type A or B? _____

**YES☐NO☐** Have you ever had a thumb, finger, or tongue sucking habit? If so, how long? _____ Speech therapy? _____

**YES☐NO☐** Do you have, or have you had, any symptoms associated with your temporomandibular joints (TMJ), such as clicking in jaws, headaches, locking of jaws, clenching or grinding? Please explain_____

**YES☐NO☐** Are you currently under medical care for any reason? If yes, what is the condition? _____
If you are taking any medication, please list_____
**YES☐NO☐** Do you have any sensitivities or allergies to any metals, such as nickel, copper, or titanium? _____
Describe any accidents or blows to the mouth or chin you have experienced_____

AUTHORIZATION AND RELEASE: I agree to be responsible for payment of all charges which are incidental to the care and treatment of the above named patient with my prior consent. I authorize Dr. Joseph Hudgins to release any information acquired in the course of my examination or treatment to third party payers and/or health practitioners. I understand that if I finance orthodontic treatment, I give my consent to have my credit report checked. I also certify the above information is correct.

Signature:_____Date:_____

**Print**