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?

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Children/Teens Only

●Has either parent had orthodontic treatment? Yes No Explain:____

●Has the patient reached puberty? Yes No

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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:**____/____/____

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