Thank you for providing this important information to help us serve you best. If you have any questions or need assistance, just ask. We're happy to help!

HULSE
ORTHODONTICS

(760) 448-1344 • HulseOrthodontics.com
6405 El Camino Real Carlsbad, CA 92009

Patient Information

NAME ____________________ PREFERRED NAME ____________________

DATE OF BIRTH ____________________ GENDER ____________________

HOME PHONE ____________________ CELL PHONE ____________________

ADDRESS ____

CITY __________ STATE ______ ZIP ______ EMAIL ____________________

EMPLOYER ____________________ OCCUPATION ____________________

EMPLOYER ADDRESS ____________________ CITY __________ STATE ______ ZIP ______

WORK PHONE ____________________ NUMBER OF YEARS EMPLOYED ____________________

HAVE WE TREATED ANY FAMILY MEMBERS? IF YES, WHO? ____________________

WHOM MAY WE THANK FOR REFERRING YOU? ____________________

MARITAL STATUS ☐ MARRIED ☐ DOMESTIC PARTNER ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ SINGLE

Spouse/Partner Information

(IF APPLICABLE)

NAME ____________________ DATE OF BIRTH ____________________

EMPLOYER ____________________ OCCUPATION ____________________

EMPLOYER ADDRESS ____________________ CITY __________ STATE ______ ZIP ______

WORK PHONE ____________________ NUMBER OF YEARS EMPLOYED ____________________

CELL PHONE ____________________ EMAIL ____________________

Primary Insurance Information

☐ CHECK HERE IF NO ORTHODONTIC COVERAGE WILL BE APPLIED

INSURANCE COMPANY ____________________ INSURANCE PHONE NUMBER ____________________

EMPLOYER/GROUP NAME ____________________ GROUP NUMBER ____________________

SUBSCRIBER/EMPLOYEE ____________________ SUBSCRIBER ID ____________________

DATE OF BIRTH ____________________ RELATIONSHIP TO PATIENT ____________________

Secondary Insurance Information

☐ CHECK HERE IF NO SECONDARY INSURANCE

INSURANCE COMPANY ____________________ INSURANCE PHONE NUMBER ____________________

EMPLOYER/GROUP NAME ____________________ GROUP NUMBER ____________________

SUBSCRIBER/EMPLOYEE ____________________ SUBSCRIBER ID ____________________

DATE OF BIRTH ____________________ RELATIONSHIP TO PATIENT ____________________

Emergency Contact Information

NAME ____________________ RELATIONSHIP TO PATIENT ____________________

HOME PHONE ____________________ CELL PHONE ____________________

Please take a moment to complete the reverse side of this form.

Medical History

PHYSICIAN ______ PHONE ______ DATE OF LAST EXAM ______

Y N

1. ARE YOU UNDER MEDICAL TREATMENT NOW? ☐ ☐
2. HAVE YOU BEEN HOSPITALIZED FOR ANY SURGICAL OPERATIONS OR SERIOUS ILLNESS IN THE PAST FIVE YEARS? ☐ ☐
3. ARE YOU TAKING MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? ☐ ☐
   IF YES, WHAT MEDICATION(S) ARE YOU TAKING?
4. DO YOU USE TOBACCO? ☐ ☐
5. ARE YOU AWARE OF BEING ALLERGIC TO ANY MEDICATIONS OR SUBSTANCE, INCLUDING METALS? ☐ ☐
   IF YES, WHAT?
6. FEMALES ONLY: ARE YOU PREGNANT, OR THINK YOU MAY BE? ☐ ☐
7. HAVE YOU EVER BEEN EVALUATED FOR AIRWAY OBSTRUCTION AND/OR SLEEP APNEA? ☐ ☐
8. EVER TAKEN BISPHOSPHONATES (EX: FOSAMAX) FOR OSTEOPOROSIS? ☐ ☐
   IF YES, SPECIFY ______
9. PLEASE CHECK ALL THAT APPLY:

HAY FEVER/ALLERGIES	☐	LEUKEMIA	☐
COLD SORES	☐	KIDNEY/LIVER DISEASE	☐
MIGRAINES	☐	ANEMIA	☐
DIABETES/GLAUCOMA	☐	CANCER	☐
RHEUMATIC FEVER	☐	JOINT REPLACEMENT/IMPLANT	☐
AIDS OR HIV INFECTION	☐	HEPATITIS/JAUNDICE	☐
CARDIAC PACEMAKER	☐	STOMACH TROUBLES/ULCERS	☐
ASTHMA (INHALER)	☐	SINUS PROBLEMS	☐
FAINTING/SEIZURES	☐	STROKE	☐
THYROID PROBLEM	☐	RADIATION THERAPY	☐
HIGH/LOW BLOOD PRESSURE	☐	RESPIRATORY PROBLEMS	☐
HEART TROUBLE	☐	BONE DISORDER	☐
EPILEPSY/CONVULSIONS	☐	OSTEOPENIA/OSTEOPOROSIS	☐
TAKING MEDICATION:	☐	REMOVAL OF ADENOIDS/TONSILS	☐

IF SO, SPECIFY: ______

Dental History

DENTIST ______

DATE OF LAST CLEANING ______

Y N

1. ARE YOU ANXIOUS OR NERVOUS ABOUT DENTAL TREATMENT? ☐ ☐
2. DO YOU REQUIRE PREMEDICATION FOR DENTAL TREATMENT? ☐ ☐
3. DO YOU FEEL PAIN TO ANY OF YOUR TEETH? ☐ ☐
4. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH? ☐ ☐
5. HAVE YOU HAD ANY HEAD, NECK, OR JAW INJURIES? ☐ ☐
   IF YES, PLEASE DESCRIBE:
6. DO YOU HAVE ANY ONGOING PROBLEMS IN YOUR JAW WITH:
   A. CHRONIC CLICKING OR POPPING? ☐ ☐
   B. PAIN? ☐ ☐
   C. DIFFICULTY OPENING OR CLOSING? ☐ ☐
   D. DIFFICULTY IN CHEWING? ☐ ☐
7. DO YOU CLENCH OR GRIND YOUR TEETH? ☐ ☐
8. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY? ☐ ☐
9. HAVE YOU EVER HAD SPEECH THERAPY? ☐ ☐
   IF YES, PLEASE DESCRIBE:
10. IS THERE ANY OUTSTANDING DENTAL TREATMENT TO BE COMPLETED? ☐ ☐
    IF YES, PLEASE DESCRIBE:
11. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING AND FLOSSING YOUR TEETH? ☐ ☐
12. DO YOU HAVE ANY OF THE FOLLOWING ORAL HABITS:
    A. NAIL BITING? ☐ ☐
    B. THUMB SUCKING? ☐ ☐
    C. TONGUE THRUST WHILE SWALLOWING? ☐ ☐
    D. MOUTH BREATHING? ☐ ☐
13. HOW MANY TIMES A DAY DO YOU BRUSH? ______
14. **PLEASE CHECK THE BOXES BELOW WHICH DESCRIBE THE PROBLEM(S) FOR WHICH YOU ARE SEEKING TREATMENT:**

CROWDING	☐	**MISSING TEETH**	☐
EXTRA SPACE	☐	**EXTRA PERMANENT TEETH**	☐
TEETH STICK OUT TOO FAR	☐	**TEETH ERUPTING IN THE WRONG POSITION**	☐
TMJ PROBLEMS	☐		
POOR BITE RELATIONSHIP	☐	**OTHER:** ______	

15. HAVE YOU EVER HAD AN ORTHODONTIC EVALUATION OR TREATMENT BEFORE? ☐ ☐
    IF SO, WHEN AND BY WHOM?

Authorization and Release

TO THE BEST OF MY KNOWLEDGE THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES TO THE PATIENT'S MEDICAL STATUS. I GIVE HULSE ORTHODONTICS PERMISSION TO PERFORM AN ORTHODONTIC EXAMINATION AND EVALUATION.

SIGNATURE OF PATIENT ______ DATE ______

PRINT NAME ______