JOSEPH T. HUNG, DMD, MMSC, PC

Orthodontics and Dentofacial Orthopedics

TODAY'S DATE: _____

Welcome to the Office of Dr. Joseph Hung! Please take a few minutes to fill out the information below. Thank you!

PATIENT INFORMATION *(Please print clearly and completely.)*

PATIENT NAME:

First Name	*M.I.*	*Last Name*	*Name you prefer to be called*

Date of Birth: ____/____/____ (*Month / Day / Year*)

Status: ☐Single ☐Married ☐Child ☐Other

Soc. Sec. No.: ____-____-____

Employer: _____

Occupation: _____

Parent/Guardian: *(if Patient under 18 years old)*

First Name	*M.I.*	*Last Name*	*Relationship*

Home Phone: (____) ____-____ ☐

Work Phone: (____) ____-____ ☐

Cell Phone: (____) ____-____ ☐

We call to confirm your appointments during normal business hours one business day before your appointment. Please check the number that is best to reach you.

Email Address: _____

Would you be interested in email confirmations? ☐Yes ☐No

Home Address:

_____
Street Address

_____
City *State* *Zip*

Mailing Address: *(if different from Home Address)*

_____
Street Address

_____
City *State* *Zip*

Financially Responsible Party: ☐Patient ☐Parent/Guardian (listed above) ☐Other: _____ (please complete below)

If Financially Responsible Party is someone other than Patient or Patient's Parent/Guardian, please provide the following information:

Name: _____

Address: _____

_____

Soc. Sec. No.: _____

Home Phone: (____) ____-____

Work/Cell Phone: (____) ____-____

General Dentist Information:

General Dentist: _____

Telephone: _____

Address: _____

_____

Dental Specialist Information:

If you are being treated by another dental specialist, please provide their information:

Specialist: _____

Specialty: _____ Tel: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 requires that healthcare providers give patients a copy of the office Notice of Privacy Practices and make good faith effort to obtain an acknowledgement of receipt of same. *You may refuse to sign this acknowledgement.*

By signing below, I confirm that I have received a copy of the office Notice of Privacy Practices.

Sign Name: _____ Date: _____

Print Name: _____

Office Use Only: *If acknowledgement is not obtained, list reason:*

☐*Patient refused to sign* ☐*Emergency Situation* ☐*Unable to communicate with patient* ☐*Other:* _____

HOW DID YOU HEAR ABOUT DR. JOSEPH HUNG?

☐Dental Office of _____
☐Friend/Colleage _____
☐*New York Family* magazine
☐Practice Website (www.manhattanortho.com)
☐Invisalign Website (www.invisalign.com)
☐Dr. Oogle Website (www.doctoroogle.com)
☐Google search
☐Citysearch
☐Other, please describe:

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TODAY'S DATE: _____

PATIENT NAME: _____ **Address:** _____

MEDICAL HISTORY

For the following questions, please check Yes, No, or Don't Know. The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

Now or in the past, have you had:

MEDICATION CONDITIONS

Please check.

Medical Condition	Yes	No	Don't Know
Birth defects or hereditary problems			
Bone fractures, any major accidents			
Rheumatoid or arthritic conditions			
Endocrine or thyroid problems			
Kidney problems			
Diabetes			
Cancer, tumor, radiation treatment or chemotherapy			
Stomach ulcer or hyperacidity			
Polio, mononucleosis, tuberculosis, pneumonia			
Problems of the immune system			
AIDS or HIV positive			
Hepatitis, jaundice or liver problems			
Fainting spells, seizures, epilepsy, or neurological problems?			
Mental health disturbance or depression			
Vision, hearing, tasting or speech difficulties			
Loss of weight recently, poor appetite			
History of eating disorder (anorexia, bulimia)			
Excessive bleeding or bruising tendency, anemia or bleeding disorder			
High or low blood pressure			
Tired easily			
Chest pain, shortness of breath or swelling ankles			
Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defect, heart murmur or rheumatic heart disease)			
Skin disorder			
Do you have a well-balanced diet			
Frequent headaches, colds or sore throats			
Hay fever, asthma, sinus trouble or hives			
Tonsil or adenoid conditions			
Osteoporosis			

ALLERGIES

Please check.

Allergies or reactions to any of the following:	Yes	No	Don't Know
Latex (gloves, balloons)			
Vinyl			
Acrylic			
Polyurethane			
Metals (jewelry, clothing snaps)			
Aspirin			
Ibuprofen (Motrin, Advil)			
Sulfa drugs			
Codeine or other narcotics			
Local anesthetics (Novocain or lidocaine)			
Plaster			
Animals			
Foods: Please specify			
Other substances: Please specify			

MEDICATION

Please circle.

Are you taking any medication, nutrient supplementation, herbal medications or non-prescription medicine? If YES, please name them.	**Yes**	**No**	**Don't know**
Medication:	**Taken for:**		
1.			
2.			
3.			
4.			
5.			

MEDICATION CONDITIONS

Please check.

Medical Condition	Yes	No	Don't Know
Do you currently have or ever had a substance abuse problem?			
Do you chew or smoke tobacco?			
Have you had any operations? Describe/Date:			
Have you ever been hospitalized? For:			
Have you ever had orthodontics? If yes, when:			

Please check.

Medical Condition	Yes	No	Don't Know
ARE YOU PREGNANT, or is there a possibility that you may be pregnant? *(women only)*			
Are you anticipating becoming pregnant? *(women only)*			
Do you have any other conditions we should know about? If so, describe:			