Douglas Huhn, D.M.D, P.A. Clete Huhn, D.D.S., P.A.

1100 SOUTH ORANGE AVENUE • ORLANDO, FLORIDA 32806 • PHONE: (407) 422-6281

Name_____ Would like to be called_____

Address_____
Street City, State Zip Code

Employer_____ Occupation_____

Home Telephone_____ Bus. Telephone_____ Cell Phone: _____

Birthdate_____ Sex_____ Marital Status: S___ M___ W___ D___ Soc. Sec #_____

How did you hear about our practice?_____Email Address:_____

PERSON RESPONSIBLE FOR ACCOUNT

Name_____ Relationship to patient _____

Address_____
Street City, State Zip Code

Employer_____ Occupation_____

Business Address_____
Street City, State Zip Code

Home Telephone_____ Bus. Telephone_____ Ext._____

Birthdate_____ Sex_____ Social Security Number _____

Primary Insurance Company_____ Employer_____

Subscriber's Name _____ Soc. Sec #_____

Group Number _____ Union or Local Number_____

Patient's Relationship to Subscriber — Self_____ Spouse_____ Child_____

If Patient is a Student — Name of School _____

Secondary Insurance Company_____ Employer_____

Subscriber's Name _____ Soc. Sec #_____

Group Number _____ Union or Local Number_____

Patient's Relationship to Subscriber — Self_____ Spouse_____ Child_____

I authorize the release of any information necessary to process my insurance claim.

Signature X_____

I hereby authorize payment to the dentist of the insurance benefits other — payable to me. A copy of this signature is as valid as the original

Signature X_____

— OVER —

GENERAL HEALTH HISTORY

Are you in good health? If no, explain _____ YES NO

Are you under a physician's care now? _____ YES NO
If yes, explain _____

Name of physician _____ City _____

Are you now taking drugs or medication? _____ YES NO
If yes, please list _____

Are you sensitive or allergic to any drugs? _____ YES NO
If yes, please list _____

Have you been hospitalized in the past two years? _____ YES NO
If yes, explain _____

Do you now have or have you had any of the following?

A.I.D.S. or HIV+	YES	NO	Herpes	YES	NO
Allergies	YES	NO	Hepatitis	YES	NO
Anemia	YES	NO	High Blood Pressure	YES	NO
Asthma or Hay Fever	YES	NO	Kidney Disease	YES	NO
Blood Diseases	YES	NO	Liver Disease	YES	NO
Cancer	YES	NO	Radiation Treatment	YES	NO
Diabetes	YES	NO	Rheumatic Fever	YES	NO
Epilepsy	YES	NO	Rheumatism or Arthritis	YES	NO
Excessive Bleeding	YES	NO	Stroke	YES	NO
Fainting Spells or Seizures	YES	NO	Stomach Ulcers	YES	NO
Heart Disease	YES	NO	Tuberculosis	YES	NO
Heart Murmur	YES	NO	Venereal Disease	YES	NO

Do you have any disease, condition, or problem not listed? _____ YES NO

WOMEN: Are you pregnant? If yes, due date _____ YES NO
Are you taking birth control pills? _____ YES NO

DENTAL HISTORY

Dental Complaint at this moment _____

Date of you last dental treatment _____/_____/_____ Last Cleaning _____/_____/_____

Do you grind or clench your teeth?	YES	NO	Do your gums bleed?	YES	NO
Pain in jaw joint?	YES	NO	Cold or Canker Sores?	YES	NO
Sore or Sensitive teeth?	YES	NO	Unpleasant taste?	YES	NO

The above information is true and I will notify you of any changes.
I Consent to whatever Dental Procedures and anesthetics are necessary for the treatment of the above named patient.
I also agree to assume full Financial Responsibility for all treatment rendered.

Signature X _____ Date _____

In case of emergency, contact: _____ Telephone _____

UPDATES AND REMARKS

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