

Hickman Orthodontics

1418 Brice Road • Reynoldsburg, Ohio 43068

Tel: 614-501-0042 • Fax: 614-501-0048

ORTHODONTIC TREATMENT FOR CHILDREN, TEENS, AND ADULTS

PATIENT INFORMATION:

Date _____

Name _____ Address _____
First Middle Last Nickname

Phone _____ Birthday _____ Age _____ Sex _____ City _____ State _____ Zip _____

Dentist Name _____ Sports or Hobbies _____

Physician Name _____ Siblings/Children _____ Birthday _____

School Name _____ Grade _____ Siblings/Children _____ Birthday _____

Musical Instruments Played _____ Whom May We Thank for Referring You? _____

FATHER OR SELF OR GUARDIAN INFORMATION

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Birthday _____ Age ____ Sex ____ Marital Status _____

SS# (Required) _____

Email _____

EMPLOYER INFORMATION

Name _____

Address _____

City _____ State _____ Zip _____

DENTAL INSURANCE COMPANY

Orthodontic Coverage? Yes ____ No ____

Policy holder name _____ DOB _____

Ins. Company Name _____

Address _____

Insurance Phone _____

ID # _____ Group# _____

MOTHER OR SPOUSE INFORMATION

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Birthday _____ Age ____ Sex ____ Marital Status _____

SS# (Required) _____

Email _____

EMPLOYER INFORMATION

Name _____

Address _____

City _____ State _____ Zip _____

DENTAL INSURANCE COMPANY

Orthodontic Coverage? Yes ____ No ____

Policy holder name _____ DOB _____

Ins. Company Name _____

Address _____

Insurance Phone _____

ID # _____ Group# _____

MEDICAL INFORMATION

	YES	NO		YES	NO		YES	NO
Any heart disease	___	___	Is patient taking any medication	___	___	Emphysema	___	___
Any respiratory disease	___	___	History of fainting or dizziness	___	___	Epilepsy	___	___
Any blood disease	___	___	Any drug addiction	___	___	Asthma, hay fever	___	___
Any liver disease	___	___	Measles/mumps/chicken pox	___	___	Tuberculosis	___	___
Any thyroid disease	___	___	Does patient smoke	___	___	Broken bones	___	___
Any kidney disease	___	___	Is patient in good health	___	___	Prolonged bleeding	___	___
HIV positive	___	___	Is height/weight normal for age	___	___	Yellow jaundice	___	___
Any venereal disease	___	___	Fever blisters	___	___	Radiation therapy	___	___
Any intestinal disease	___	___	Has patient had physical this year	___	___	Chemical therapy	___	___
Any bone disease	___	___	Has patient reached puberty	___	___	Blood transfusions	___	___
Nervous/emotional problems	___	___	Heart murmur	___	___	Is the patient allergic to anything?	___	___
High or low blood pressure	___	___	Mononucleosis	___	___	What? _____		
Problems with wounds healing	___	___	Hepatitis	___	___	List any medications being taken _____		
Any tumors or cancer	___	___	Polio	___	___	_____		
Rheumatic/yellow/scarlet fever	___	___	Diabetes	___	___	_____		
Acquired immune deficiency	___	___	Anemia	___	___	Are you aware of any other disease, conditions or problems not listed above that we should know about? _____		
Is patient under medical care	___	___	Hemophilia	___	___			
Rheumatism or arthritis	___	___	If patient is female, at what age did menstruation begin? _____					

DENTAL HISTORY

Does the patient have or ever had any of the following habits?

	YES	NO		YES	NO		YES	NO
Has patient seen a general dentist in the last year?	___	___	Cheek, tongue or			Clenching teeth	___	___
Any pain, clicking or discomfort in or near the ears?	___	___	lip chewing	___	___	Tongue thrusting	___	___
Has the mouth, face or teeth been injured by a fall or accident?	___	___	Thumb sucking	___	___	Grinding teeth	___	___
Have you been informed of missing or extra permanent teeth?	___	___	Mouth breathing	___	___	Speech problems	___	___
Are you aware of any "gum" problems?	___	___	Fingernail biting	___	___			
Has anyone advised antibiotics before a dental exam?	___	___					YES	NO
Have the patient's tonsils or adenoids been removed?	___	___	Has patient been examined by an orthodontist before?	___	___		___	___
Is the patient happy with their smile?	___	___	If yes, when? _____					
Does the patient want to improve their smile or bite?	___	___	Have other members of the family had orthodontic treatment?	___	___		___	___
Would the patient mind wearing braces?	___	___	If yes, were you happy with the results?	___	___		___	___
Do you feel the patient can benefit from orthodontic treatments?	___	___	If no, why? _____					

In your own words, what is the orthodontic problem? _____

What would you like orthodontic treatment to accomplish? _____

Patient Signature

Date

Parent Signature

ON THIS DATE, THE ABOVE GIVES PERMISSION FOR DIAGNOSTIC RECORDS TO BE TAKEN. I UNDERSTAND THAT IF I CHOOSE NOT TO GO FORWARD WITH ORTHODONTIC TREATMENT, THERE WILL BE A FEE OF \$250 FOR THE WORK THAT HAS BEEN COMPLETED THUS FAR. IF THE PATIENT HAS ORTHODONTIC INSURANCE, THE INSURANCE COMPANY WILL BE BILLED, AND I WILL BE RESPONSIBLE FOR ANY REMAINING BALANCE.