Hickman Orthodontics

6899 E. Main St • 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
Any heart disease	___	___
Any respiratory disease	___	___
Any blood disease	___	___
Any liver disease	___	___
Any thyroid disease	___	___
Any kidney disease	___	___
HIV positive	___	___
Any venereal disease	___	___
Any intestinal disease	___	___
Any bone disease	___	___
Nervous/emotional problems	___	___
High or low blood pressure	___	___
Problems with wounds healing	___	___
Any tumors or cancer	___	___
Rheumatic/yellow/scarlet fever	___	___
Acquired immune deficiency	___	___
Is patient under medical care	___	___
Rheumatism or arthritis	___	___

	YES	NO
Is patient taking any medication	___	___
History of fainting or dizziness	___	___
Any drug addiction	___	___
Measles/mumps/chicken pox	___	___
Does patient smoke	___	___
Is patient in good health	___	___
Is height/weight normal for age	___	___
Fever blisters	___	___
Has patient had physical this year	___	___
Has patient reached puberty	___	___
Heart murmur	___	___
Mononucleosis	___	___
Hepatitis	___	___
Polio	___	___
Diabetes	___	___
Anemia	___	___
Hemophilia	___	___

If patient is female, at what age did menstruation begin?____________________

	YES	NO
Emphysema	___	___
Epilepsy	___	___
Asthma, hay fever	___	___
Tuberculosis	___	___
Broken bones	___	___
Prolonged bleeding	___	___
Yellow jaundice	___	___
Radiation therapy	___	___
Chemical therapy	___	___
Blood transfusions	___	___
Is the patient allergic to anything?	___	___

What?________________________________

List any medications being taken__________

____

Are you aware of any other disease, conditions or problems not listed above that we should know about?__________________________

DENTAL HISTORY

	YES	NO
Has patient seen a general dentist in the last year?	___	___
Any pain, clicking or discomfort in or near the ears?	___	___
Has the mouth, face or teeth been injured by a fall or accident?	___	___
Have you been informed of missing or extra permanent teeth?	___	___
Are you aware of any "gum" problems?	___	___
Has anyone advised antibiotics before a dental exam?	___	___
Have the patient's tonsils or adenoids been removed?	___	___
Is the patient happy with their smile?	___	___
Does the patient want to improve their smile or bite?	___	___
Would the patient mind wearing braces?	___	___
Do you feel the patient can benefit from orthodontic treatments?	___	___

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

	YES	NO
Cheek, tongue or lip chewing	___	___
Thumb sucking	___	___
Mouth breathing	___	___
Fingernail biting	___	___

	YES	NO
Clenching teeth	___	___
Tongue thrusting	___	___
Grinding teeth	___	___
Speech problems	___	___

	YES	NO
Has patient been examined by an orthodontist before?	___	___
If yes, when?_______________________________		
Have other members of the family had orthodontic treatment?	___	___
If yes, were you happy with the results?	___	___
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.