

Hickory Flat Dental Group

**7840 Hickory Flat Hwy
Woodstock, GA 30188
770-479-8654
770-479-9082 fax**

Patient's Name _____ Home Phone _____ Cell # _____

Birthdate _____ Age _____ Sex _____ Email _____

Home Address _____ City _____ State _____ Zip Code _____

Employed By _____ Business Phone _____

Address _____ Occupation _____

Spouse's Name _____

Social Security # _____ Driver's License # _____ State _____ Marital Status _____

Spouse's Occupation _____ Spouse's Social Security # _____

Patient's Dentist _____ Patient's Physician _____

Address _____ Address _____

Referred By _____

Friend or Relative Who is a Patient In This Office? _____

Person Responsible For Account _____ Phone _____

Billing Address _____ City _____ State _____ Zip Code _____

Emergency Contact Person and Phone: _____

Are You Covered By Dental Insurance That Provides for Orthodontic Treatment? _____

If So, List Name Of Insurance Company, Address, Phone # and Policy Number Below.

Patient Has Been Treated by Physician For

	YES	NO
Artificial Hip or Hear Valve Replacement	<input type="checkbox"/>	<input type="checkbox"/>
AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Hives/Rash	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>
Inflammatory Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Polio	<input type="checkbox"/>	<input type="checkbox"/>
Nervous Problems	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
VD	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Tumor or Cancer	<input type="checkbox"/>	<input type="checkbox"/>
TB	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine/Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Bone Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged Bleeding/Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Removal of Tonsils and Adenoids	<input type="checkbox"/>	<input type="checkbox"/>

Covered Employee's Name _____

Date of Birth _____ Social Security # _____

Employer's Name _____

Address _____

Phone _____

MEDICAL HISTORY

YES NO

Patient is in good health

Patient is under physician's care

If so, for what reason _____

Date of last medical checkup _____

Are there any impending operations?

If so, describe _____

Patient is taking prescription medications

If so, list _____

Patient is allergic to medicines

If so, list _____

Has puberty been reached (Start of menstruation or voice change)

If so and within last 2 years, when? _____

Is the patient presently pregnant?

DENTAL HISTORY

	YES	NO	
Patient has had a recent dental check-up	<input type="checkbox"/>	<input type="checkbox"/>	Date: _____
Patient has had a previous orthodontic examination	<input type="checkbox"/>	<input type="checkbox"/>	Date: _____ Whom: _____
Are you a transfer orthodontic patient?	<input type="checkbox"/>	<input type="checkbox"/>	Date treatment started _____

Previous orthodontist name _____

ADDRESS	CITY	STATE	ZIP	PHONE
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In your own words please explain reason for visit today _____

	YES	NO	
Blow or injury to face or teeth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Finger or thumb sucking habit	<input type="checkbox"/>	<input type="checkbox"/>	_____
Night time teeth clenching or grinding habit	<input type="checkbox"/>	<input type="checkbox"/>	_____
Speech problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swallowing problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Clicking or pain when opening jaws	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ever treated for problems of the jaw joint or facial muscle spasms	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty in breathing through nose	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dentist has removed primary teeth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dentist has removed permanent teeth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgery to repair cleft lip and or cleft palate	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gum disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High intake of sweets	<input type="checkbox"/>	<input type="checkbox"/>	_____
Parents have had orthodontic treatment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Patient resembles father	<input type="checkbox"/>	<input type="checkbox"/>	_____
Patient resembles mother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Patient is adopted	<input type="checkbox"/>	<input type="checkbox"/>	_____
I feel orthodontics is needed for one or all of these reasons	<input type="checkbox"/>	<input type="checkbox"/>	_____
To improve chewing efficiency	<input type="checkbox"/>	<input type="checkbox"/>	_____
To improve facial appearance	<input type="checkbox"/>	<input type="checkbox"/>	_____
To improve long term dental health	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____
Patient's reaction to orthodontic treatment is:			
Eager	<input type="checkbox"/>	<input type="checkbox"/>	_____
Complacent	<input type="checkbox"/>	<input type="checkbox"/>	_____
Accepts whatever is recommended	<input type="checkbox"/>	<input type="checkbox"/>	_____
Antagonistic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please describe the patient's individual character or nature (for example, quiet, outgoing, self-conscious, responsible leader, one of the group, etc.)

If you have any additional concerns or questions you wish the doctors to be aware of or you wish the doctors to answer, please describe:

To the best of my knowledge, the above information is correct. I give consent for the initial exam and for records, if needed, to determine the necessity of orthodontic treatment and accept responsibility for payment of records, which includes x-rays, models and photographs. In addition, I understand those records may be used for professional reference, display, orthodontic journals, books, meetings and patient education. I give my permission to Dr. Wendy Katz's office to obtain a credit report on me, if credit is extended to me for orthodontic treatment.

DATE	Signature of Person Completing Form
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