

Hickory Flat Dental Group

7840 Hickory Flat Hwy

Woodstock, GA 30188

770-479-8654

770-479-9082 fax

Patient's Name _____ Nickname _____ Birthdate _____ Age _____
LAST FIRST MIDDLE MO. DAY YR.

Home Address _____
STREET CITY STATE ZIP

How Many Years At This Address? _____ Home Phone _____ School & Grade _____ Sex _____

Patient's Interests: _____
SPORTS, HOBBIES, MUSIC, CHURCH OR SCHOOL ACTIVITIES ETC.

Brother's Age _____ Sisters Age _____ (CIRCLE AGES THAT HAVE HAD OR ARE HAVING ORTHODONTIC TREATMENT)

Patient's Dentist _____ Patient's Physician _____ Referred by _____

Address _____ Address _____ Address _____

Close Friend Or Relative Who Is A Patient In This Office _____

Father/Husband
 Name _____
LAST FIRST MIDDLE

Address (If Different From Patient) _____
STREET CITY STATE ZIP

Employed By _____

Employer's Address _____

Occupation _____ Social Security No. _____

How Long Employed? _____ Driver's License # _____ State _____

Phone _____

HOME (IF DIFFERENT FROM PATIENT) BUSINESS PHONE

Person Responsible _____

For Account _____

NAME

Mother/Wife
 Name _____
LAST FIRST MIDDLE

Address (If Different From Patient) _____
STREET CITY STATE ZIP

Employed By _____

Employer's Address _____

Occupation _____ Social Security No. _____

How Long Employed? _____ Driver's License # _____ State _____

Phone _____

HOME (IF DIFFERENT FROM PATIENT) BUSINESS PHONE

Billing

Address (Street) _____

Does Patient Live With Mother and Father? Yes No With Whom? _____ City _____ State _____ Zip _____

Whom Shall We _____

Contact If Unable to Reach Mother Or Father? _____

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"/> |
| 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"/> |

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

If So, List Name of Insurance Company And Policy Number _____

Covered Employee's Name _____

Date of Birth _____ Social Security No. _____

Employer's Name _____

Address _____

Phone _____

MEDICAL HISTORY

- | | YES | NO |
|--|--------------------------|--------------------------|
| Patient is in good health | <input type="checkbox"/> | <input type="checkbox"/> |
| Patient is under physician's care | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, for what reason | <input type="checkbox"/> | <input type="checkbox"/> |
| Date of last medical checkup | <input type="checkbox"/> | <input type="checkbox"/> |
| Are there any impending operations? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, describe | <input type="checkbox"/> | <input type="checkbox"/> |
| Patient is taking prescription medications | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, list | <input type="checkbox"/> | <input type="checkbox"/> |
| Patient is allergic to medicines | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, list | <input type="checkbox"/> | <input type="checkbox"/> |
| Has puberty been reached (Start of menstruation or voice change) | <input type="checkbox"/> | <input type="checkbox"/> |
| If so and within last 2 years, when? | <input type="checkbox"/> | <input type="checkbox"/> |
| Is the patient presently pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |

DENTAL HISTORY

YES NO

Patient has had a recent dental check-up Date: _____

Patient has had a previous orthodontic examination Date: _____ Whom: _____

Are you a transfer orthodontic patient? Date treatment started _____

Previous orthodontist name _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____

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 jaw	<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 nos	<input type="checkbox"/>	<input type="checkbox"/>
Dentist has removed primary 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 _____		

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 _____		

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 _____

DATE _____ Signature of Person Completing Form _____