

# PICKARD ORTHODONTICS

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## Patient Information and Health History

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_  
Patient Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_ SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Phone \_\_\_\_\_ Best daytime phone \_\_\_\_\_

\*\*Would you like us to text you reminders? Yes  No  E-mail Address \_\_\_\_\_  
Are any other family members currently in orthodontic treatment? Y/N Doctor \_\_\_\_\_  
Have any other family members received orthodontic treatment? Y/N Doctor \_\_\_\_\_  
Have you visited an orthodontist before? Y/N Date of last visit \_\_\_\_\_  
Anything you would like to discuss with the doctor in private? Y/N \_\_\_\_\_

## Responsible Party Information

Marital Status: Single  Married  Widowed  Divorced  Separated  Domestic Partners

Person Responsible for Account (if not self)

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address (if different from yours) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Employer \_\_\_\_\_ E-Mail \_\_\_\_\_  
Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

\*Insurance Information:

Insurance Company Name \_\_\_\_\_ Group or Plan # \_\_\_\_\_  
Insurance Company Phone # \_\_\_\_\_ Insurance Company Address \_\_\_\_\_  
Subscriber SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

## Dental History

Current Dentist \_\_\_\_\_ Seen in last 6 months? Y/N  
Dentist's Concerns? \_\_\_\_\_  
Do you require antibiotics before dental treatment? Y/N Have your adenoids or tonsils been removed? Y/N  
Have you been informed of any missing or extra permanent teeth? Y/N \_\_\_\_\_  
Have there been injuries to the your face, mouth, or chin? \_\_\_\_\_  
Do you ever had pain/tenderness in the jaw joint? (TMJ/TMD) Y/N \_\_\_\_\_  
Have you ever had any of the following habits?  
 Grinding teeth  Chewing/ Eating Problems  
 Mouth Breather  Speech Problems  
What are the main concerns that you would like orthodontics to accomplish? \_\_\_\_\_  
\_\_\_\_\_

Who may we thank for referring you to our practice? \_\_\_\_\_

Would you be willing to engage in elective oral surgery to obtain "the ideal orthodontic result" if necessary? Y/N

## Medical History

Physician's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Please describe your physical health:  Good  Fair  Poor

Are you currently under the care of a physician? Y/N \_\_\_\_\_

Have you seen a physician in the last 12 months? Y/N \_\_\_\_\_

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

Y N Abnormal Bleeding

Y N Hearing Impairment

Y N Neckaches/ Headaches

Y N Heart Murmur

Y N Kidney Problems

Y N Allergy to Latex/Metals

Y N High Blood Pressure

Y N Arthritis or Osteoporosis

Y N HIV or ARC

Y N Liver Problems/ Hepatitis

Y N Tuberculosis

Y N Radiation Treatment

Y N Allergies/ Asthma

Y N Bone Density Issues

Y N Diabetes

Y N Cancer

Y N Thyroid

Y N Allergies to Drugs

Y N Psychiatric care/ Emotional Problems

Y N Rheumatic/Scarlet Fever

Y N Pregnancy/ month # \_\_\_\_\_

Any history of major illnesses? Y/N \_\_\_\_\_

Please list all drugs you are currently taking: \_\_\_\_\_

Please list all drugs you are allergic to: \_\_\_\_\_

## Insurance/ Fees

**Insurance:** To avoid misunderstanding regarding dental insurance, we wish the persons responsible to know that all professional services rendered are charged directly to them and that they are personally responsible for payment or fees. We will prepare necessary forms to help the persons responsible to obtain benefits from the insurance companies for receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient. All information contained on this form will remain confidential. **We submit insurance as a courtesy to our patients. It is in no way a form of guaranteed payment from the insurance company.**

**Fees:** The first visit to our office is complimentary.

## Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

I hereby authorize release of any information related to insurance claim. I consent to examination by the doctor and I authorize payment of any insurance benefits.

\*\*\*Would you like us to text you reminders? Y/N \_\_\_\_\_ Best Daytime phone # to reach you \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA**