

PICKARD ORTHODONTICS

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Patient Information and Health History

Patient Name _____ Birthdate ____/____/____ Age _____ Sex ____
Patient Address _____ City _____ State ____ Zip _____
Phone _____ Best Daytime Phone _____ Would you like to receive text reminders? Y/N
E-Mail Address _____ Nickname _____
Hobbies, Sports _____ School _____ Grade _____
Siblings/Ages/Male or Female _____
Are any other family members currently in orthodontic treatment? Y/N Doctor _____
Have any other family members received orthodontic treatment? Y/N Doctor _____
Has your child 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

Parents Marital Status: Single Married Widowed Divorced Separated Domestic Partners

Father: Father Step Father Guardian Name _____
Address (if different from child's) _____
Home Phone _____ Work Phone _____ Cell Phone _____
Employer _____ E-Mail _____
Subscriber SSN _____ DOB _____

*Insurance Information:

Insurance Company Name _____ Group or Plan # _____
Insurance Company Phone # _____ Insurance Company Address _____

Mother: Mother Step Mother Guardian Name _____
Address (if different from child's) _____
Home Phone _____ Work Phone _____ Cell Phone _____
Employer _____ E-Mail _____
Subscriber SSN _____ DOB _____

*Insurance Information:

Insurance Company Name _____ Group or Plan # _____
Insurance Company Phone # _____ Insurance Company Address _____

Dental History

Current Family Dentist _____ Seen in last 6 months? Y/N
Dentist's Concerns? _____
Does the child require antibiotics before dental treatment? Y/N Have the 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 child's face, mouth, or chin? _____
Has the child ever had pain/tenderness in the jaw joint? (TMJ/TMD) Y/N _____
Does/Did the child have any of the following habits?
 Grinding teeth Thumb/finger habit Prolonged Bottle/Pacifier
 Mouth Breather Speech Problems Chewing/ Eating 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 child's physical health: Good Fair Poor

Is child currently under the care of a physician? Y/N _____

Has child 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 _____

Has Puberty Begun? Y/N

Has Menstruation Begun? (Girls) Y/N

Please list all drugs your child is currently taking: _____

Please list all drugs your child is 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 child's 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.

Signature

Date

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