ELITE ORTHODONTICS

We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to take a few minutes to fill out this form as completely as possible.

Patient Information - Adult

Name _____ Gender _____ Marital Status _____

Address _____ Zip _____

Birthdate _____ Social Security _____ E-mail _____

Main Phone _____ Secondary Phone _____

How did you hear about our office? _____ Occupation _____

Spouse / Partner / Additional Contact Information

Name _____ Gender _____ Marital Status _____

Address _____ Zip _____

Birthdate _____ Social Security _____ E-mail _____

Main Phone _____ Secondary Phone _____ Relationship _____

Primary Dental Insurance Information

Primary Dental Plan Name _____ Insurance Phone No. _____

Policy Holder Name _____ Relationship to Patient _____

Policy Holder Birthday _____ Policy Holder SSN _____

Employer _____ Group No. _____

Member/Employee I.D. _____ Issue Date _____

Secondary Dental Insurance Information

Primary Dental Plan Name _____ Insurance Phone No. _____

Policy Holder Name _____ Relationship to Patient _____

Policy Holder Birthday _____ Policy Holder SSN _____

Employer _____ Group No. _____

Member/Employee I.D. _____ Issue Date _____

Dental History

General Dentist Name _____ Phone _____ Last Visit _____

Please select YES or NO for the following questions - Do not leave blank

Y N Grind or Clench Teeth
Y N Injury to Face, Jaw, Teeth or Mouth
Y N Discomfort from Teeth or Gums
Y N Pain, Tenderness or Noise in Either Jaw
Y N Smoking/Tobacco Use
Y N Mouth Breathing
Y N Missing/Extra Teeth
Y N Frequent Sore Throats
Y N Food Trapped Between Teeth
Y N Oral Habits/Tongue Thrust
Y N Requires Premedication

If any of the above dental questions were answered 'YES', please explain: _____

_____

_____

_____

Medical History

Physician Name _____ Phone _____ Last Visit _____

Please select YES or NO for the following questions - Do not leave blank

Y N Rheumatic Fever
Y N Tuberculosis/Lung Disease
Y N Asthma
Y N Kidney Disease
Y N Sleep Breathing Disorder
Y N Blood Disorders
Y N Low/High Blood Pressure
Y N HIV/AIDS
Y N Hepatitis
Y N Cancer/Tumor/Cyst
Y N Arthritis
Y N Received Radiation Treatment
Y N Heart Condition
Y N Nervous Disorders
Y N Bone Disorders/Bone Loss
Y N Diabetes
Y N Seizures/Epilepsy
Y N Treated for Emotional Problems
Y N Ever Been Hospitalized
Y N Endocrine Problems
Y N Hormone Therapy
Y N Autism Spectrum Disorder/ ADD/ADHD

If any of the above medical questions were answered 'YES', please explain: _____

_____

_____

FEMALE PATIENTS:

To the best of your knowledge, are you pregnant? Y N If yes, how long? _____

Y N MEDICATIONS

Please list **ANY** medications your are currently taking

_____

_____

_____

Y N ALLERGIES

Please list **ANY** allergies you are aware of

_____

_____

_____

Orthodontic Consult

Yes No Have you ever had or been evaluated for orthodontic treatment? If yes, please describe

_____

_____

What are the main concerns that you would like orthodontics to accomplish?

_____

_____

Please list the names of any family or friends currently in the practice

_____

_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment. It is my responsibility to inform this office of any changes in my medical status. I will not hold the doctor or staff responsible for any errors or omissions that I have made in the completion of this form.

Patient Name _____ **Signature** _____ **Date** _____