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 - Adolescent

Name _____ Gender _____ Preferred Name _____

Address _____ Zip _____

Birthdate _____ Main Phone _____ School _____

Patient resides with ❍ Both Parents ❍ Mother ❍ Father ❍ Step Parent ❍ Shared Custody ❍ Guardian

Name and ages of other children in your family _____

How did you hear about our office? _____ Hobbies _____

Responsible Party Information

(Person accompanying child to most appointments, making treatment decisions and financially responsible)

Name _____ Marital Status _____

Address _____ Zip _____

Birthdate _____ Social Security _____ E-mail _____

Main Phone _____ Secondary Phone _____ Occupation _____

Other Guardian Information

(Other parent or step-parent, insurance subscriber or person occasionally accompanying patient to appointments)

Name _____ Marital Status _____

Address _____ Zip _____

Birthdate _____ Social Security _____ E-mail _____

Main Phone _____ Secondary Phone _____ Occupation _____

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 Speech Problems/Therapy
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 Oral Habits/Tongue Thrust
Y N Frequent Sore Throats
Y N Mouth Breathing
Y N Requires Premedication
Y N Food Trapped Between Teeth
Y N Missing/Extra Teeth

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 Heart Condition
Y N Autism Spectrum Disorder/ ADD/ ADHD
Y N Sleep Breathing Disorder
Y N Low/High Blood Pressure
Y N Blood Disorders
Y N HIV/AIDS
Y N Hepatitis
Y N Cancer/Tumor/Cyst
Y N Arthritis
Y N Endocrine Problems
Y N Hormone Therapy
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

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

_____

_____

Y N MEDICATIONS
Please list **ANY** medications your child is currently taking

_____

_____

Y N ALLERGIES
Please list **ANY** allergies you are aware of

_____

_____

Orthodontic Consult

Yes No Has your child 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.

Parent/Guardian Name _____ **Signature** _____ **Date** _____