



Dr. Sherif Elhady . Dr. Taz Elmady . Dr. Nakysa Kheirandish

Patient's Name: _____
Last First Middle Sex

Address: _____
Street City State Zip

Date of Birth: _____ Social Security if over 18: _____ School: _____

Cell Phone: _____ Home Phone: _____

Email: _____

General Dentist: _____ Last Visited: _____

How did you hear about us? Google/Facebook/Yelp/ Instagram/ Sports Team/ Mailer/ Friend/ Family/ Dentist/ Employee

If Family/Friend, Dentist or Starff Member please provide name _____ Please tell us why you are interested? _____

If a minor, does patient reside with both parents? YES NO If NO, please explain _____

Primary Responsible Party/Insurance Subscriber Information:

Name: _____ Relationship: _____

Address (if different than patient) _____

Birthdate: _____ Email: _____ SS# _____

Insurance Company: _____ ID# _____ EmployerName/Group# _____

Insurance Address: _____ Insurance Phone# _____

Secondary Responsible Party/Insurance Subscriber Information:

Name: _____ Relationship: _____

Address (if different than patient) _____

Birthdate: _____ Email: _____ SS# _____

Insurance Company: _____ EmployerName/Group# _____ ID# _____

Insurance Address: _____ Insurance Phone# _____

Emergency Information:

Name of nearest relative not living with you: _____ Phone#: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

****You may refuse to sign this section****

I, _____, have received a copy of this office's Notice of Privacy Practices.

Name (Please Print) _____ Signature _____ Date: _____

FOR PATIENTS OVER THE AGE OF 18

I give consent to the health professionals at Tru Othodontics to release my personal records and information to the person/persons listed below..

Name of Person/Persons: _____ Signature of Patient _____

Medical History

Patient's Physician

	Yes	No	
• Are you in good health?	<input type="radio"/>	<input type="radio"/>	Explain _____
• Do you have any history of major illness or hospitalization?	<input type="radio"/>	<input type="radio"/>	Explain _____
• Are you currently under the care of a physician?	<input type="radio"/>	<input type="radio"/>	Explain _____
• Do you currently take any medications?	<input type="radio"/>	<input type="radio"/>	List & explain _____
• Are you allergic to any medications?	<input type="radio"/>	<input type="radio"/>	List & explain _____
• Have your tonsils and adenoids been removed?	<input type="radio"/>	<input type="radio"/>	When? _____
• Are you pregnant?	<input type="radio"/>	<input type="radio"/>	
• Have you ever taken bisphosphonates for osteoporosis or other bone disease?	<input type="radio"/>	<input type="radio"/>	
• Is there any other medical conditions we should be aware of?	_____		

Do you currently have or have you ever had any of the conditions listed below? Please check the appropriate response.

Yes	No		Yes	No		Yes	No	
<input type="radio"/>	<input type="radio"/>	Heart Attack	<input type="radio"/>	<input type="radio"/>	Anemia	<input type="radio"/>	<input type="radio"/>	Tuberculosis
<input type="radio"/>	<input type="radio"/>	Heart Murmur	<input type="radio"/>	<input type="radio"/>	Bleeding Disorders	<input type="radio"/>	<input type="radio"/>	Asthma
<input type="radio"/>	<input type="radio"/>	Rheumatic Fever	<input type="radio"/>	<input type="radio"/>	Hepatitis	<input type="radio"/>	<input type="radio"/>	Herpes
<input type="radio"/>	<input type="radio"/>	Rheumatic Heart Disease	<input type="radio"/>	<input type="radio"/>	HIV/AIDS	<input type="radio"/>	<input type="radio"/>	Kidney Disorders
<input type="radio"/>	<input type="radio"/>	Congenital Heart Defect	<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>	Epilepsy
<input type="radio"/>	<input type="radio"/>	Stroke	<input type="radio"/>	<input type="radio"/>	Leukemia	<input type="radio"/>	<input type="radio"/>	Fainting/Dizzy Spells
<input type="radio"/>	<input type="radio"/>	Mononucleosis	<input type="radio"/>	<input type="radio"/>	Bone Disorders	<input type="radio"/>	<input type="radio"/>	Endocrine Disorders

Children/Teens Only

- Has either parent had orthodontic treatment? Yes No Explain _____
- Has the patient reached puberty? Yes No **Boy:** Voice changed? Yes No **Girl:** Started menstruation? Yes No

Dental History

- When was your last dental exam/cleaning? _____
- Do you have any extra missing, loose, or sensitive? Yes No Explain _____
- Any injuries to your face, mouth, or teeth? Yes No Explain _____
- Do you currently suck your thumbs or fingers? Yes No Explain _____
- Do you have any speech problems? Yes No Explain _____
- Are you a mouth-breather? Yes No
- Any clicking, popping, or pain in your jaw joint (TMJ)? Yes No Explain _____
- Do you clench or grind your teeth? Yes No
- Do you suffer frequent headaches? Yes No Explain _____
- Does your jaw ever hurt? Yes No When? _____
- Have you ever had an orthodontic evaluation before? Yes No May we ask, who did you see? _____
- Have you ever experienced any unfavorable reaction to dentistry? Yes No _____

• Please tell why you are interested in orthodontia? _____

The information given about my health history in this form is accurate and complete to the best of my knowledge. I hereby give my consent to perform necessary diagnostic tests, including x-rays to evaluate my dental health. I agree that all of the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidences and it is my responsibility to inform this office of any changes in my medical status. I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.

Signature of patient/parent: _____

Date: _____