tru ORTHODONTICS
by Dr. Sherif Elhady

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 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: _____ SSN#_____

Insurance Company: _____ Employer Name/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 (HIPPA)

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 care professionals at Tru Orthodontics to release my personal records and information to the person/persons listed below…

Name of Person/Persons: Signature of Patient

Medical History .	Yes	No	*Patient's Physician* _____
· Are you in good health?	☐	☐	Explain
· Do you have any history of major illness or hospitalization?	☐	☐	Explain
· Are you currently under the care of a physician?	☐	☐	Explain
· Do you currently take any medications?	☐	☐	List & explain
· Are you allergic to any medications?	☐	☐	List & explain
· Have your tonsils and adenoids been removed?	☐	☐	When?
· Are you pregnant?	☐	☐	
· Have you ever taken bisphosphonates for osteoporosis or other bone disease?	☐	☐	
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	
☐	☐	Heart Attack	☐	☐	Anemia	☐	☐	Tuberculosis
☐	☐	Heart Murmur	☐	☐	Bleeding Disorders	☐	☐	Asthma
☐	☐	Rheumatic Fever	☐	☐	Hepatitis	☐	☐	Herpes
☐	☐	Rheumatic Heart Disease	☐	☐	HIV/AIDS	☐	☐	Kidney Disorders
☐	☐	Congenital Heart Defect	☐	☐	Diabetes	☐	☐	Epilepsy
☐	☐	Stroke	☐	☐	Leukemia	☐	☐	Fainting/Dizzy Spells
☐	☐	Mononucleosis	☐	☐	Bone Disorders	☐	☐	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
- 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? _____
  May we ask, who did you see? _____
- Have you ever had an orthodontic evaluation before? ☐ 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 ***Signature of parent*** ***Signature of guardian*** ***Date***