



Dr. Sherif Elhady . Dr. Farnaz Younessian . Dr. Mahsa Mortasavi . Dr. Cindy Ding . Dr. Taz Elmady

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: \_\_\_\_\_ 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.

<input type="radio"/> Yes	<input type="radio"/> No	Heart Attack	<input type="radio"/> Yes	<input type="radio"/> No	Anemia	<input type="radio"/> Yes	<input type="radio"/> No	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

Signature of parent

Signature of guardian

Date