trü ORTHODONTICS

Dr. Sherif Elhady . Dr. Mahsa Mortasavi . 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 _____

Fairfax • Gainesville • Herndon • Springfield

Medical History

Patient's Physician

	Yes	No	
• 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** 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 othodontia?** _____

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 responsability to inform this office of any changes in my medical status. I hereby authorize the release of any infomation related to insurance claims. Iconsent to the examination by the doctor and I authorize payment of any insurance benefits to the office.

Signature of patient/parent: _____ *Date:* _____