ELHADY ORTHODONTICS
SHERIF N. ELHADY DDS, MS, PC

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Patient Information

Date: _____

Patient's Name: _____
Last First Middle Sex M/F

Address: _____
Street City/State Zip

Birthdate: _____ Social Security # _____School:_____

Primary Contact Phone: **Home/Cell/Work** _____ Other Phone: **Home/Cell/Work** _____

If Cell, Which Carrier:_____ Email:_____

General Dentist: _____ Last Visited: _____

How did you hear about us? **Friend/Family/Dentist/Internet** _____

Does patient reside with both parents? **YES NO** If NO, please explain _____

Responsible Party Information/ Dental Insurance Information

Name: _____Relationship: _____

Address (if different than patient)_____ ____Work Phone: _____

Birthdate: _____ Email: _____ SSN# _____

Employer: _____ Occupation: _____ No. Years Employed: _____

Secondary Responsible Party Name: _____Relationship to Patient:_____

Address (if different than patient): _____Work Phone:_____

Birthdate: _____ Email: _____ SSN# _____

Employer: _____ Occupation: _____ No. Years Employed: _____

Insurance Information: Primary / Secondary Insurance

Policy Owner's Full Name: _____ SS#: _____

Birthdate: _____ Relationship to Patient: _____ Employer: _____

Insurance Company: _____Group #: _____ ID #: _____

Insurance Address: _____ ____Insurance Phone #: _____

Secondary Policy Owner's Full Name: _____ SS#: _____

Birthdate: _____ Relationship to Patient: _____ Employer: _____

Insurance Company: _____Group #: _____ ID #: _____

Insurance Address: _____Insurance Phone #_____

TELL US ABOUT YOURSELF

What would you like to see in an Orthodontist?_____

Nickname_____ Grade Level_____

Favorite Hobby_____ Favorite Food_____

Favorite Animal_____ Favorite Person_____

Favorite Sport_____ Favorite Musical Artist_____

Musical Instrument Played_____ Siblings_____

Emergency Information

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

Address: _____

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.
I understand that where appropriate, credit bureau reports may be obtained.

Signature (Responsible Party if minor) _____

Name (Please Print) _____

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 Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__ Individual refused to sign __ Communications barriers prohibited obtaining the acknowledgement __ An emergency situation prevented us from obtaining acknowledgement

Medical History	***Patient's Physician***		
• Are you in good health?	Yes	No	Explain_____
• Do you have any history of major illness or hospitalization?	Yes	No	Explain_____
• Are you currently under the care of a physician?	Yes	No	Explain_____
• Do you currently take any medications?	Yes	No	List & explain_____
• Are you allergic to any medications?	Yes	No	List & explain_____
• Have your tonsils and adenoids been removed?	Yes	No	When?_____
• Are you pregnant?	Yes	No	
• Have you ever taken bisphosphonates for osteoporosis or other bone disease?	Yes	No	
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
- Boys: has his voice changed? Yes No
- Girls: has she started menstruation? Yes No

Dental History

- When was your last dental exam/cleaning? _____
- Do you have any extra teeth? Yes No Explain_____
  -missing, loose, sensitive teeth? Yes No _____
- Have you ever had 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
- Do you have 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
- Does your jaw ever hurt? Yes No Explain_____
- Have you ever had an orthodontic evaluation before? Yes No When?_____
  May we ask, who did you see?_____
- ***In your own words, please tell us why you are interested in orthodontic treatment?*** _____ _____

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.

Signature of patient, parent, or guardian_____ Date_____/_____/_____