Alec N. Elchahal DMD•MS•PC

Specialist in Orthodontics for Children & Adults

Welcome

To assist us in providing the most comprehensive care, please provide the following personal information and health history.

Thank you

PERSONAL INFORMATION

Name: ____
FIRST MIDDLE LAST

Sex: ______ Age: ______ Date of Birth: ______/______/______ Email ______________________
MONTH DAY YEAR

Home Address: ______________________________ Home Phone: (____) ________________

Cell Phone: (____) ________________________

Employed By: ______________________________ Bus. Phone: (____) ________________

Dentist: ______________________________

Physician: ______________________________

Whom can we thank for referring you:

____

SPOUSES INFORMATION

(IF APPLICABLE)

Name: ______________________________
FIRST MIDDLE LAST

Employed By: ______________________________

____

Bus. Phone: (_____) ________________

What are your chief concerns regarding your Orthodontic Treatment (improve esthetics, improve function, etc.)

____

Please describe your reasons for considering orthodontic treatment.

❏ Improve Facial Appearance ❏ Enhanced Long-term Dental Health ❏ Improve Functional Health

❏ Other: ____

INSURANCE INFORMATION

IF YOU HAVE DENTAL INSURANCE THAT YOU WOULD LIKE US TO FILE, PLEASE PROVIDE THE FOLLOWING INFORMATION.

Name of Person Who Holds the Policy: ______________________________

Their Current Mailing Address: ______________________________

SS#: _______-_____-________ Member ID# on Card: __________________ DOB: ____/____/____ Group#: ________________

Employer Name and Address: ______________________________

____

Relationship to Patient: ______________________________

Name of Insurance Carrier: ______________________________

Address to send Dental Claims: ______________________________

Phone Number for Insurance Carrier ______________________________

I authorize the release of medical and dental information to insurance carriers and to other health care providers involved in the care of this patient and the use of records by Dr. Elchahal for teaching purposes or scientific publication. In the future please advise the doctor of any changes in your medical or dental health while under care in this office.

______________________________ ____/____/____
SIGNATURE OF PATIENT DATE

PLEASE COMPLETE OTHER SIDE

MEDICAL HISTORY

Do you have a history of any of the following? ***(Check when yes)***

- ❏ Asthma
- ❏ Diabetes
- ❏ Blood Disorder
- ❏ Epilepsy
- ❏ Hepatitis
- ❏ Heart Problems
- ❏ Glaucoma
- ❏ Rheumatic Fever
- ❏ Frequent Headaches
- ❏ Ear Problems
- ❏ Tonsil or Adenoid removal

  At What Age _________
- ❏ HIV
- ❏ Tuberculosis
- ❏ Allergies ***(IF YES, PLEASE LIST)***

____

____

Are You? ***(CHECK WHEN YES)***

- ❏ In good health?
- ❏ Under a physician's care? ***If so, for what reason?***

____

____

____

- ❏ Taking any medication? ***If yes, please list***

____

- ❏ In the need for orthodontic treatment caused by an accident?

  If so, please give date and description

____

____

____

Please note any other factors the doctor should know about your health.

____

____

____

DENTAL HISTORY

- ❏ Bleeding Gums
- ❏ Had permanent teeth removed
- ❏ Injury to face or teeth
- ❏ Night time teeth grinding
- ❏ Clicking or pain when opening jaws
- ❏ Chronic Facial Pain

Please note any other factors the doctor should know about your dental health. __________________________

____

____

- ❏ Recent dental check-Up. Date: ___/____/____
- ❏ Previous orthodontic treatment. Date: ___/___/___

  By Whom: ___________________________________
- ❏ Previous examination by an orthodontist.

  Date: ____/_____/_____

  By Whom: ___________________________________
- ❏ Previous Periodontal evaluation.

  Date: ____/_____/_____

  By Whom: ___________________________________