Alec N. Elchahal
Specialist in Orthodontics for Children & Adults
DMD•MS•PC

Welcome

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

Thank you

PERSONAL INFORMATION

Name: ______________________________ Nickname: ______________
FIRST MIDDLE LAST

Sex: ______ Age: ______ Date of Birth: _____/_____/_____ School: ______________ Grade: ______

Dentist: ______________________ Physician: ______________________

Referred by: ______________________ Is Child Adopted: ❏ Yes ❏ No

MOTHER

Name: ______________________

Address: ______________________

____

Home Phone: (_____) ______________

Cell Phone: (_____) ______________

Email Address: ______________________

Employed By: ______________________

Work Phone: (_____) ______________

Social Security #:_________-________-__________

FATHER

Name: ______________________

Address: ______________________

____

Home Phone: (_____) ______________

Cell Phone: (_____) ______________

Email Address: ______________________

Employed By: ______________________

Work Phone: (_____) ______________

Social Security #:_________-________-__________

What are your chief concerns regarding your child's orthodontic condition? (overbite, crowding, etc.)

____

Please describe your reasons for considering orthodontic treatment.

❏ Improve facial appearance ❏ Improve Functional Health ❏ Enhanced Long-Term Dental Health

❏ Other______________________________________

Please describe your child's attitude toward orthodontic treatment.

❏ Eager ❏ Complacent ❏ Antagonistic

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 child's medical or dental health while under care in this office.

PLEASE COMPLETE OTHER SIDE

______________________________ _____/_____/_____
SIGNATURE OF PATIENT DATE

______________________________ _____/_____/_____
SIGNATURE OF PARENT OR GUARDIAN DATE

THE PATIENTS MEDICAL HISTORY

Does your child have a history of any of the following? (*CHECK WHEN YES*)

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

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

____

____

Is the Patient? ***(CHECK WHEN YES)***

❏ In good health?

❏ Under a physician's care? ***If so, for what reason.***

____

____

____

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

____

❏ Is 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 patient's health.

____

____

____

DENTAL HISTORY

- ❏ Thumb or Finger Sucking ***(Presently)***
- ❏ Thumb or Finger Sucking ***(Previously)***
- ❏ Had Primary Teeth Removed
- ❏ Had Permanent Teeth Removed
- ❏ Speech Problems
- ❏ Swallowing Problems
- ❏ Injury to Face or Teeth
- ❏ Night Time Teeth Grinding
- ❏ Clicking or Pain When Opening Jaws

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

❏ Previous orthodontic treatment. Date: ___/___/___

By Whom: ____

❏ Previous examination by an orthodontist.

Date: ____/_____/_____

By Whom: ____

Please note any other factors the doctor should know about

patient's dental health. ______________________________________

____

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