



# ELROD ORTHODONTICS

JERALD E. ELROD • DDS, PC • SPECIALIST IN ORTHODONTICS

Welcome! Our specialty is creating smiles and to do this we treat people, not just teeth.  
We care about your total health and appreciate your time in completing this health history.

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## PATIENT INFORMATION

**Patient's Name** \_\_\_\_\_  Male  Female

Last

First

Middle

Nickname

Address \_\_\_\_\_

Street

City

State

Zip

Home Phone \_\_\_\_\_

Birthdate \_\_\_\_\_

Age \_\_\_\_\_

Social Security # \_\_\_\_\_

If Patient is a minor, give parent's or guardian's name \_\_\_\_\_

Do you have legal custody of this child?  Yes  No

List brothers/sisters & age(s) \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Friends or family treated by Dr. Elrod \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION

**Name** \_\_\_\_\_

Last

First

Middle

Marital Status \_\_\_\_\_

Residence \_\_\_\_\_

Street

City

State

Zip

Mailing Address \_\_\_\_\_

Street

City

State

Zip

How long at this address: \_\_\_\_\_

Email \_\_\_\_\_

Cell Phone \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Ext. \_\_\_\_\_

Previous Address (if less than 3 years) \_\_\_\_\_

Street

City

State

Zip

Social Security # \_\_\_\_\_

Birthdate \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

No. Years Employed \_\_\_\_\_

**Spouse's Name** \_\_\_\_\_

Last

First

Middle

Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

No. Years Employed \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email \_\_\_\_\_

Social Security # \_\_\_\_\_

Birthdate \_\_\_\_\_

Work Phone \_\_\_\_\_

Ext. \_\_\_\_\_

## INSURANCE INFORMATION

Orthodontic Coverage  Yes  No  Don't Know

**Primary Insured's Name** \_\_\_\_\_

Insured's Soc. Sec. # \_\_\_\_\_

Insurance Company \_\_\_\_\_

Group No. \_\_\_\_\_

Plan No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Do you have dual coverage  Yes  No

**Secondary Insured's Name** \_\_\_\_\_

Insured's Soc. Sec. # \_\_\_\_\_

Insurance Company \_\_\_\_\_

Group No. \_\_\_\_\_

Plan No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

## EMERGENCY INFORMATION

Name of nearest friend/relative not living with you \_\_\_\_\_

Complete Address \_\_\_\_\_

Street

City

State

Zip

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Ext. \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email \_\_\_\_\_

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

**MEDICAL HISTORY**

Physician \_\_\_\_\_ Date of last visit \_\_\_\_\_

Current physical health?  Good  Fair  Poor

**Circle YES or NO: If YES:**

YES NO Are you taking any medications: List: \_\_\_\_\_

YES NO Are you allergic to any medications? List: \_\_\_\_\_

YES NO Have you had any serious injury to head or neck? Describe: \_\_\_\_\_

YES NO Have tonsils or adenoids been removed? When: \_\_\_\_\_

YES NO If patient is a minor, has puberty begun: Age: \_\_\_\_\_

**Check any medical condition that you have had or currently have:**

- |   |   |   |  |  |
|---|---|---|--|--|
| <input type="checkbox"/> AIDS/HIV+              | <input type="checkbox"/> Blood Disorders    | <input type="checkbox"/> Endocrine Problems     | <input type="checkbox"/> Hemophilia          | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Bone Disorders     | <input type="checkbox"/> Epilepsy/Convulsions   | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Sinus Problems  |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Handicaps/Disabilities | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Thyroid         |
| <input type="checkbox"/> Asthma or Hay Fever    | <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Heart Defects          | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis    |
| <input type="checkbox"/> Allergy to Latex/Metal | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Heart Murmur           | <input type="checkbox"/> Migraines           | <input type="checkbox"/> Tumor or Cancer |

List any other medical condition or problem \_\_\_\_\_

**DENTAL HISTORY**

Dentist \_\_\_\_\_ Date of last visit \_\_\_\_\_

What would you like orthodontics to accomplish? \_\_\_\_\_

**Circle YES or NO (if YES, please fill in details):** \_\_\_\_\_

YES NO Have you ever experienced any unfavorable reactions to dentistry? \_\_\_\_\_

YES NO Have there been any injuries to the face, mouth, teeth or chin? \_\_\_\_\_

YES NO Do you have any missing or extra permanent teeth? \_\_\_\_\_

YES NO Do your gums routinely bleed when you brush? \_\_\_\_\_

YES NO Do you have any speech problems? \_\_\_\_\_

YES NO Do you have a thumb, finger or tongue thrust problem? \_\_\_\_\_

YES NO Do you breathe through your mouth, or are your lips often parted: \_\_\_\_\_

YES NO Have you seen an orthodontist before? Who? \_\_\_\_\_ When? \_\_\_\_\_

YES NO Has anyone in the family received orthodontic treatment? Who? \_\_\_\_\_ When? \_\_\_\_\_

YES NO Do you have any pain or soreness around your eyes, neck or back? If so:

Which side?  Left  Right  Both How frequent?  Constant  Periodic

YES NO Do you feel you clench or grand your teeth during the day or at night? \_\_\_\_\_

YES NO Are you aware of your jaw joints clicking, popping or locking? If so: \_\_\_\_\_

Which side?  Left  Right  Both How frequent?  Constant  Periodic

YES NO Do you have frequent headaches? Do you take pain relievers?  Yes  No Amount? \_\_\_\_\_

YES NO Are you aware that orthodontic appointments will infringe on some school or work time?

YES NO Are you apprehensive toward dental visits? \_\_\_\_\_

Classify patients expressed desire for improved dental appearance:

Very Desirous  Average Desire  Casual Desire  Objects

How many times does the patient brush daily? 0 1 2 3 4 Floss daily? 0 1 2 3

**THANKYOU FOR FILLING OUT THIS FORM COMPLETELY**

I understand the information that I have given is correct to the best of my knowledge that it will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in the medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that may be needed during diagnosis and treatment. I also understand that this office reserves the right to verify the credit status of potential patients and / or parents of patients prior to extending credit for treatment fees.

Signature of Patient/Parent or Guardian \_\_\_\_\_

Date \_\_\_\_\_

**OFFICE USE ONLY**

I verbally reviewed the medical/dental information with the patient named herein. Initials: Doctor \_\_\_\_\_ TC \_\_\_\_\_ Date \_\_\_\_\_