



**Alec N. Elchahal
& Associates, DMD•MS•PC**
Specialists in Orthodontics for Children & Adults
Johns Creek • Hamilton Mill • Vickery
770-622-1177

Welcome

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

Thank you

PERSONAL INFORMATION

Name: _____ Email _____
FIRST MIDDLE LAST

Sex: _____ Age: _____ Date of Birth: _____ / _____ / _____ Home Phone: (_____) _____
MONTH DAY YEAR

Home Address: _____ Cell Phone: (_____) _____

City: _____ State: _____ Zip: _____ Bus. Phone: (_____) _____

Employed By: _____

Social Security #: _____ - _____ - _____

Dentist: _____

Physician: _____

Whom can we thank for referring you:

**SPOUSES INFORMATION
(IF APPLICABLE)**

Name: _____
FIRST MIDDLE LAST

Employed By: _____

Bus. Phone: (_____) _____

Cell Phone: (_____) _____

Social Security #: _____ - _____ - _____

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 you 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: _____