



**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: _____ Nickname: _____
FIRST MIDDLE LAST

Sex: _____ Age: _____ Date of Birth: ____/____/____ School: _____ Grade: _____

Dentist: _____ Physician: _____

Referred by: _____ Is Child Adopted: Yes No

MOTHER Would you be interested in a complimentary Orthodontic screening today for yourself? _____

FATHER Would you be interested in a complimentary Orthodontic screening today for yourself? _____

Name: _____

Name: _____

Address: _____

Address: _____

Home Phone: (_____) _____

Home Phone: (_____) _____

Cell Phone: (_____) _____

Cell Phone: (_____) _____

Email Address: _____

Email Address: _____

Employed By: _____

Employed By: _____

Work Phone: (_____) _____

Work Phone: (_____) _____

Social Security #: _____ - _____ - _____

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: _____

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.

SIGNATURE OF PATIENT

_____/_____/_____
DATE

SIGNATURE OF PARENT OR GUARDIAN

_____/_____/_____
DATE

PLEASE COMPLETE OTHER SIDE

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. _____
