3357 Merlin Dr.
Idaho Falls, ID 83404
(208) 522-9600

ELISON Orthodontics

214 E. 1st North
Rexburg, ID 83440
(208) 356-3300

PATIENT INFORMATION

Name: _____ Sex: ☐ M ☐ F D.O.B.: _____
First Middle Last Preferred Name

Address: _____ Apt # _____ City: _____ State: _____ Zip: _____

Phone: _____ Work Phone: _____ **Email:** _____

RESPONSIBLE PARTY INFORMATION

☐ **Father** ☐ **Self** ☐ **Other**

Name: _____
First Middle Last

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Phone: _____ Work Phone: _____

Cell Phone: _____ **Email:** _____

D.O.B.: _____ Marital Status: _____

Does this person live in same household as the patient? _____

S.S. # _____

Emergency Contact: _____ Phone: _____

☐ **Mother** ☐ **Spouse** ☐ **Other**

Name: _____
First Middle Last

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Phone: _____ Work Phone: _____

Cell Phone: _____ **Email:** _____

D.O.B.: _____ Marital Status: _____

Does this person live in same household as the patient? _____

S.S. # _____

Emergency Contact: _____ Phone: _____

EMPLOYER INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

No. Years Employed: _____ Occupation: _____

Insurance Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Ext: _____

Group #: _____ Policy #: _____

Orthodontic Coverage? ☐ Yes ☐ No ☐ Not Sure

EMPLOYER INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

No. Years Employed: _____ Occupation: _____

Insurance Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Ext: _____

Group #: _____ Policy #: _____

Orthodontic Coverage? ☐ Yes ☐ No ☐ Not Sure

OTHER INFORMATION

Dentist Name: _____

Other Children: _____ Age _____

_____ Age _____

_____ Age _____

_____ Age _____

Who may we thank for referring you to our office? _____

Other Children: _____ Age _____

_____ Age _____

_____ Age _____

_____ Age _____

MEDICAL INFORMATION

Yes	No		Yes	No		Yes	No	
☐	☐	Any heart disease?	☐	☐	Acquired Immune Deficiency Syndrome?	☐	☐	Yellow Jaundice?
☐	☐	Any respiratory diesase?	☐	☐	Is patient under medical care?	☐	☐	Anemia?
☐	☐	Any blood disease?	☐	☐	Any history of fainting or dizziness?	☐	☐	Polio?
☐	☐	Any broken bones?	☐	☐	Any nervous/emotional problems?	☐	☐	Epilepsy/seizures?
☐	☐	Any thyroid disease?	☐	☐	Does the patient smoke?	☐	☐	Latex allergy?
☐	☐	Any kidney disease?	☐	☐	Any drug addiction?	☐	☐	Fever blisters?
☐	☐	H.I.V. positive?	☐	☐	Is the patient pregnant at this time?	☐	☐	Tuberculosis?
☐	☐	Any venereal disease?	☐	☐	Measles/Mumps/Chicken Pox?	☐	☐	Diabetes?
☐	☐	Any intestinal disease?	☐	☐	Is the patient in good health?	☐	☐	Blood transfusions?
☐	☐	Any bone disease?	☐	☐	Any high/low blood pressure?	☐	☐	Chemical dependence?
☐	☐	Allergic to anything?	☐	☐	Any problems with wounds healing?	☐	☐	Radiation therapy?
☐	☐	Any endocrine problems?	☐	☐	Heart murmer/defect?	☐	☐	Hemophilia?
☐	☐	Any prolonged bleeding?	☐	☐	Mononucleosis?	☐	☐	Asthma or hay fever?
☐	☐	Does the patient bruise easily?	☐	☐	Hepatitis?	☐	☐	Any liver disease?
☐	☐	Rheumatic/Yellow/Scarlet Fever?	☐	☐	Emphysema?	☐	☐	Rheumatism or arthritis?
						☐	☐	Any tumors or cancer?
						☐	☐	Any condition needing MRI follow-up?

Explain any "yes" answers. _____

_____

_____

_____

List any medications the patient is taking. _____

_____

List any problems not mentioned above that we should know about. _____

_____

DENTAL HISTORY

Yes	No		Yes	No	
☐	☐	Has the patient seen a general dentist in the last year?	☐	☐	Mouth breathing
☐	☐	Any pain, clicking, or discomfort in or near the patient's ears?	☐	☐	Fingernail biting
☐	☐	Has the patient's mouth, face, or teeth been injured by a fall or accident?	☐	☐	Clenching teeth
☐	☐	Have you been informed of missing or extra permanent teeth?	☐	☐	Tongue thrusting
☐	☐	Does the patient have any "gum" problems?	☐	☐	Grind teeth
☐	☐	Have the patients tonsils or adenoids been removed?	☐	☐	Speech problems
☐	☐	Is the patient happy with their "smile?"	☐	☐	Ever been examined by an orthodontist before?
☐	☐	Does the patient want to improve their "smile?"			If yes, when? _____
☐	☐	Cheek, tongue, or lip chewing	☐	☐	Have other members of the family had orthodontic treatment?
☐	☐	Thumb sucking			

In your own words, what is the orthodontic problem? _____

What would you like orthodontic treatment to accomplish? _____

X _____ _____ X _____

Patient Signature | Date | Parent or Guardian Signature (if required)

FOR OFFICE USE ONLY

_____

_____

_____

_____

_____