Ellis Moon Orthodontics

We would like to welcome you to the office of Dr. Randy Ellis and Dr. Audrey Moon.
The benefits of a happy, healthy smile are immeasurable. A beautiful smile is a wonderful asset.
Please fill out this form completely. The better we communicate, the better we can care for you.

1 About You

Today's Date_____

Name_____

I prefer to be called_____ ☐ Male ☐ Female

Home Address_____

_____
CITY STATE ZIP

☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Separated

Hm # (____) _____ Wk # (____) _____

Cell / Other # (____) _____ DL # _____

Email Address _____

Employer_____

Employer's Address_____

How long there?_____ Occupation_____

Where & When are the best times to reach you?

_____

Whom may we thank for referring you? _____

_____

Other family members seen by us _____

_____

General Dentist _____

Last Visit Date _____

2 Spouse Information

His/Her Name _____

Employer_____

Hm # (____) _____ Wk # (____) _____

Birthdate_____

Person Responsible for Account _____

Hm # (____) _____ Wk # (____) _____

Billing Address_____

Relation_____ SS #_____

Employer_____ DL #_____

3 Orthodontic Insurance

Primary

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name_____

Insurance Co. Address _____

Insurance Co. Phone #_____

Member / Subscriber ID #_____

Group # (Plan, Local or Policy #) _____

Policy Owner's Name _____

Relationship to Patient_____

Policy Owner's Birthdate _____

Policy Owner's Employer_____

Secondary

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name_____

Insurance Co. Address _____

Insurance Co. Phone #_____

Member / Subscriber ID #_____

Group # (Plan, Local or Policy #) _____

Policy Owner's Name _____

Relationship to Patient_____

Policy Owner's Birthdate _____

Policy Owner's Employer_____

In the event of an emergency, is there someone who lives near you that we should contact?

His/Her Name _____

Relation_____

Hm # (____) _____ Wk # (____) _____

Continued on back

4 Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name _____

Phone # _____

Date of Last Visit _____

Your current physical health is ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain _____

Are you taking any prescription or over-the-counter drugs? ☐ Yes ☐ No

Please list each one _____

_____

For Women:

Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Week # _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y	N	Anemia	Y	N	Heart Murmur
Y	N	Artificial Bones/Joints	Y	N	Heart Surgery/Pacemaker
Y	N	Artificial Valves	Y	N	Hemophilia/Abnormal Bleeding
Y	N	Arthritis	Y	N	Hepatitis
Y	N	Asthma	Y	N	High/Low Blood Pressure
Y	N	Blood Transfusion	Y	N	HIV+ / AIDS
Y	N	Cancer/Chemotherapy	Y	N	Hospitalized for Any Reason
Y	N	Radiation Treatment	Y	N	Kidney Problems
Y	N	Congenital Heart Defect	Y	N	Mitral Valve Prolapse
Y	N	Diabetes	Y	N	Psychiatric Problems
Y	N	Difficulty Breathing	Y	N	Rheumatic/Scarlet Fever
Y	N	Drug/Alcohol Abuse	Y	N	Severe/Frequent Headaches
Y	N	Emphysema	Y	N	Shingles
Y	N	Epilepsy/Seizures/Fainting	Y	N	Sinus Problems
Y	N	Fever Blisters/Herpes	Y	N	Tuberculosis (TB)
Y	N	Glaucoma	Y	N	Ulcers/Colitis
Y	N	Heart Attack/Stroke	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had

_____

_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Dental Anesthetic	Y	N	Penicillin
Y	N	Any Metal/Plastic	Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Codeine	Y	N	Latex	Y	N	Other

Please list any other drugs that you are allergic to _____

_____

3 Dental History

What are the main concerns that you would like orthodontics to accomplish?

_____

_____

_____

Have you ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Have there been any injuries to the ☐ face, ☐ mouth, ☐ teeth, or ☐ chin?

Do you have any speech problems? _____

_____

Do you generally breath through your mouth

when awake? ☐ Yes ☐ No

when asleep? ☐ Yes ☐ No

Do you have any missing or extra permanent teeth? ☐ Yes ☐ No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

SIGNATURE DATE

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein.

Doctor's Comments: Initials _____ Date _____

_____

_____

_____