



elvebak
orthodontics

Welcome to Our Office!

Bryan S. Elvebak, DDS, MS

Patient Information

Patient Name _____ Date ___/___/___
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ - _____ - _____ Cell Phone _____ - _____ - _____
 SS# _____ - _____ - _____ Birth date ___/___/___ Patient Age ___ yr. ___ mo.
 E-mail address _____ School _____
 How did you hear about our office? _____ Patient's Dentist _____
 Sibling's names (ages) _____ () _____ () _____ ()

Responsible Party Information

Responsible Party's Name _____ Relationship to patient _____
Father/Guardian Name _____
 Mailing Address _____ City _____ State _____ Zip _____
 Home Ph. _____ - _____ - _____ Work Ph. _____ - _____ - _____ SS# _____ - _____ - _____ Birth date ___/___/___
 Employer _____ No. yrs _____
 Employer address _____ Occupation _____
Mother/Guardian Name _____
 Mailing Address _____ City _____ State _____ Zip _____
 Home Ph. _____ - _____ - _____ Work Ph. _____ - _____ - _____ SS# _____ - _____ - _____ Birth date ___/___/___
 Employer _____ No. yrs _____
 Employer address _____ Occupation _____

Insurance Information

Insured's Name _____ Birth date ___/___/___ Insured's SS # _____ - _____ - _____
 Insurance Company _____ Policy # _____ Group # _____
 Insurance Company address _____
 Insurance Company Phone # _____ - _____ - _____ Insured's Employer _____
 Secondary Insured's Name _____ Insured's SS # _____ - _____ - _____
 Secondary Insurance Company _____ Policy # _____ Group _____
 Secondary Insurance Company address _____
 Secondary Insured's Employer _____

Emergency Information

Emergency Contact (other than guardian) _____
 Relationship _____ Daytime Ph. _____ - _____ - _____ Alternative Ph. _____ - _____ - _____

I certify that all of the above information is true and it is my responsibility to inform this office of any changes.

Signature (Guardian's signature if a minor) _____ Date ___/___/___
 Relationship to the patient _____

Bryan S. Elvebak, D.D.S., M.S.

Orthodontics for Children & Adults

Health History

Initial Date ___/___/___

Update 1 ___/___/___

Update 2 ___/___/___

Medical History

Please Check Yes or No if the patient has or has ever had...

- | Y | N | |
|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Joint swelling or Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Bone Disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis or Liver Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Emotional Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS / HIV |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Prolonged Bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Endocrine Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Tonsils Removed |
| <input type="checkbox"/> | <input type="checkbox"/> | Adenoids Removed |

Please list dates and specifics for all "Yes" answers: _____

List any allergies: _____

List medications presently being taken: _____

List any serious illness or operation not listed above: _____

Is the Patient currently under a physicians care? _____

Physician's Name _____

Reason _____

Dental History

Please Check Yes or No if the patient has or has ever had...

- | Y | N | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Any injury to face, mouth, teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Thumb, finger or lip sucking habit(s)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Any speech problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | Mouth breathing when asleep, awake? |
| <input type="checkbox"/> | <input type="checkbox"/> | Any known missing permanent teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Any known extra permanent teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Any teeth removed by extraction? When? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Tongue thrust? |
| <input type="checkbox"/> | <input type="checkbox"/> | Any wind instruments played? |
| <input type="checkbox"/> | <input type="checkbox"/> | Clenching or Grinding of teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronically sore or bleeding gums? |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaw Pain, popping, grinding, locking? |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty chewing or swallowing food? |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Headaches? If Yes, how frequent? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle tenderness or stiffness in neck/jaw? |
| <input type="checkbox"/> | <input type="checkbox"/> | Ringling of ear, dizziness? |
| <input type="checkbox"/> | <input type="checkbox"/> | Previous treatment for TMJ or joint problems? |

Please list dates and specifics for all "Yes" answers: _____

Does patient visit his/her dentist regularly? _____

Has an Orthodontist been consulted previously? _____

Reason: _____

Has patient experienced a sudden increase in height?: _____

Does any member of the family or close relative(s) have a similar arrangement of the teeth or similar appearance of the jaws? Explain _____

Please list any other dental information known, and not listed above: _____