Ronald H. Ellingsen D.D.S., M.S.D.
Specialist in Orthodontics

We are pleased to welcome you to Ellingsen Smiles Orthodontics! Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you.

Patient Information

*Name*_____ *Sex ( ) M ( ) F*_____
Last Name First Name MI Parent Name(s)

*Address*_____*City*_____*Zip*_____

*Phone(home)*_____ *Phone(cell)*_____

*E-mail(primary)*_____ *E-mail(other)*_____

*Age*_____ *Birthdate* _____ *If patient is a minor are parents: Married( ) Single( ) Widowed( ) Separated( ) Divorced( )*

*Whom may we thank for referring you?*_____

*Notify in case of Emergency*_____*Phone*_____

Primary Insurance

*Person Responsible for Account*_____
Last Name First Name Initial

*Relation to Patient*_____*Birthdate*_____*Soc Sec #*_____

*Address (if different from patient)*_____*Phone* _____

*City*_____ *State*_____*Zip*_____

*Person Responsible Employed by*_____*Occupation* _____

*Business Address*_____*Business Phone* _____

*Insurance Company*_____*Group #*_____

*Name of other dependents under this plan*_____

Additional Insurance

Is patient covered by additional Insurance? ( ) Yes ( ) No

*Subscriber Name*_____
Last Name First Name Initial

*Relation to Patient*_____*Birthdate*_____*Soc Sec #*_____

*Address (if different from patient)*_____*Phone #*_____

*City*_____*State*_____*Zip*_____

*Subscriber Employed by*_____*Business Phone*_____

*Insurance Company*_____*Group #*_____

*Name of other dependents under this plan*_____

PLEASE COMPLETE BOTH SIDES

Medical History

*Physician's Name*_____*Dentist's Name*_____

*Patient's Height*_____ *Weight*_____ *Mother's Height*_____ *Father's Height*_____

*Brother's Ages*_____ *Sister's Ages* _____
Women: Are you pregnant? ( ) Y ( ) N

Check (x) if you have had any of the following:

( )AIDS	*( )Cancer*	*( )Hepatitis*
( )Allergies	*( )Diabetes*	*( )Heart Disease*
( )Arteriosclerosis	*( )Dizziness*	*( )Hearing Disorder*
( )Autoimmune Disorder	*( )Epilepsy*	*( )Kidney Disease*
( )Blood Disease	*( )Endocrine Problems*	*( )Ringing of Ears*
( )High Blood Pressure	*( )Emotional Problems*	*( )Sleep Disturbance*
( )Low Blood Pressure	*( )Frequent sore throats/Tonsillitis*	*( )Snoring*
( )Bone Disorders	*( )Have Speech Problems*	*( )Other*_____

*Please list any medication you are presently taking*_____

*Are you allergic to any medication?*_____

*Do you require antibiotic pre-medication when going to the dentist?*_____

What are your main concerns you (or the parent) have about your teeth or jaws?

( )"Buck teeth"	*( )Irregular facial proportions*	*( )Clicking jaw joint*
( )Crowding	*( )Prominent jaw*	*( )Headaches and facial pain*
( )Gum disease	*( )Receding jaw*	*( )Jaw pain*
( )Gummy smile		*( )Limited jaw opening*
( )Irregularly shaped teeth		*( )Ringing/stuffiness of ears*
( )Missing teeth		*( )Other* _____
( )Overbite		
( )Protrusion of teeth		
( )Spaces		

Are there any other family members with similar orthodontic conditions?
*( )Father ( )Mother ( )Brother ( )Sister ( )Other*_____

Do you breath through your mouth rather than your nose? ( )Seldom ( )Sometimes ( )Usually

*How often do you have dental check-ups?*_____*When was your last dental check-up?*_____

*Have you ever received trauma or injury to your teeth, face, jaws, or head?*_____

*Are there any other medical, dental, or surgical problems not covered?*_____

*Have you had a previous orthodontic consultation or treatment?*_____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. If there is any change in my medical status I will inform the orthodontist.

I authorize my insurance company to pay Ronald H. Ellingsen, DDS, MSD all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible whether or not paid by insurance and that I am still liable for any outstanding balance even if treatment is finished prior to payment in full.

*Signature*_____*Date*_____