|  |  |  |
| --- | --- | --- |
|  | ZACH FRAZIER ORTHODONTICS4909 FOREST AVENUEDOWNERS GROVE, IL 60515 |  |

 ADULT MEDICAL AND DENTAL HISTORY

**PATIENT INFORMATION:** TODAY’S DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_

|  |  |
| --- | --- |
| PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First MI Last |  |
| STREET ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_ | AGE: \_\_\_\_\_\_\_\_\_DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_ |
| PREFERRED PHONE #: (\_\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Home / Work / Cell)SECONDARY PHONE #: (\_\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Home / Work / Cell) | MALE: |
| EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | FEMALE: |
| EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

**MAIN CONCERNS:**

WHAT ARE YOUR MAIN REASONS FOR SEEKING ORTHODONTIC TREATMENT? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL AND INSURANCE INFORMATION:**

|  |  |  |
| --- | --- | --- |
| **PRIMARY DENTAL INSURANCE** |  | **SECONDARY DENTAL INSURANCE** |
| INSURANCE NAME |  |  | INSURANCE NAME |  |
| INSURANCE PHONE # |  |  | INSURANCE PHONE # |  |
| SUBSCRIBER NAME |  |  | SUBSCRIBER NAME |  |
| SUBSCRIBER ID |  |  | SUBSCRIBER ID |  |
| SUBSCRIBER SSN |  |  | SUBSCRIBER SSN |  |
| SUBSCRIBER DOB | \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_\_ |  | SUBSCRIBER DOB | \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_\_ |
| GROUP PLAN # |  |  | GROUP PLAN # |  |
| ORTHO COVERAGE? | YES / NO / UNSURE |  | ORTHO COVERAGE? | YES / NO / UNSURE |

**RELEASE**: I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance.

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_**

**DENTAL HISTORY:**

|  |  |  |
| --- | --- | --- |
| DENTIST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | LOCATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City State | LAST VISIT: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_\_ |
| REASON FOR LAST VISIT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

HAVE YOU EVER HAD AN ORTHODONTIC EXAM AND EVALUATION? YES / NO

**PLEASE ANSWER THE FOLLOWING QUESTIONS:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Clenching/Grinding of teeth? | Y | N |  | Injury to face, mouth, teeth or chin? | Y | N |
| Thumb/Finger sucking habit? | Y | N |  | Speech problems? | Y | N |
| Tongue thrust habit? | Y | N |  | Jaw joint problems or soreness in TMJ? | Y | N |
| Lip or cheek biting habit? | Y | N |  | Chipped teeth? | Y | N |
| Mouth breathing or trouble breathing through nose?  | Y | N |  | Late erupting or missing adult teeth? | Y | N |
| Unfavorable reaction or traumatic dental visit? | Y | N |  | Gum disease? | Y | N |
| Unusual change to face or bite? | Y | N |  |
| Snoring or sleep apnea? | Y | N |  | Previous orthodontic treatment? | Y | N |

**MEDICAL HISTORY:**

|  |
| --- |
| PHYSICIAN NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ARE YOU IN GOOD HEALTH? YES / NO |
| ARE YOU CURRENTLY TAKING ANY MEDICATIONS? YES / NOIF YES, PLEASE LIST MEDICATION AND CONDITION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| PLEASE LIST ALLERGIES TO ALL MEDICATIONS, FOODS, ETC: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| DO YOU PRE-MEDICATE WITH ANTIBIOTICS FOR DENTAL PROCEDURES? YES / NO |

**PLEASE ANSWER THE FOLLOWING QUESTIONS:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Allergy to latex? | Y | N |  | Respiratory problems, asthma, TB? | Y | N |
| Allergy to metal? | Y | N |  | Cardiovascular problems, heart problems, murmurs, blood pressure, heart defect? | Y | N |
| Allergy to local anesthetics (lidocaine, novacaine or other)? | Y | N |  | Gastrointestinal problems, liver problems, hepatitis? | Y | N |
| Cancer, tumor, radiation treatment, or chemotherapy?  | Y | N |  | Kidney problems? | Y | N |
| Skin problems?  | Y | N |  | Musculoskeletal problems, arthritis, injuries? | Y | N |
| Neurological problems, migraines, seizures, epilepsy? | Y | N |  | Immunologic problems, influenza, HIV/AIDS? | Y | N |
| Eyes / Ears / Nose / Throat problems? | Y | N |  | Herpes, syphilis, gonorrhea? | Y | N |
| Tonsils/adenoids removed? | Y | N |  | Cleft lip/palate? | Y | N |
| Genetic or hereditary problems? | Y | N |  | Eating disorders, anorexia, bulimia? | Y | N |
| Endocrine problems, diabetes, thyroid problems? | Y | N |  | Mental health problems, depression? | Y | N |

DO YOU HAVE ANY MEDICAL PROBLEM NOT LISTED ABOVE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE:

I have read the above questions and understand them. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of the form. I will notify my orthodontist of any changes to my medical or dental health.

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_**