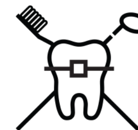
ZACH FRAZIER ORTHODONTICS

4909 FOREST AVENUE

DOWNERS GROVE, IL 60515



CHILD MEDICAL AND DENTAL HISTORY

PATIENT INFORMATION:

TODAY'S DATE: ____ / ____ / ______

PATIENT: ____
First MI Last

STREET ADDRESS: ____

AGE: _________

CITY: __________________________ STATE: ______ ZIP: _________

DOB: ____ / ____ / ______

MALE: ☐

FEMALE: ☐

SIBLINGS AND AGES: _____________________________________

ACTIVITIES/SPORTS: ______________________________________

SCHOOL: _____________________________ GRADE: ____________

PARENT/GUARDIAN INFORMATION:

MOTHER: ____
First MI Last

MARITAL STATUS: _________

STREET ADDRESS: ____ (Same as above ☐)

EMPLOYER: _______________

CITY: __________________________ STATE: ______ ZIP: _________

PREFERRED PHONE #: (_________)_____________ Home / Work / Cell

OTHER PHONE #: (_________)________________ Home / Work / Cell

EMAIL (if preferred):

____

FATHER: ____
First MI Last

MARITAL STATUS: _________

STREET ADDRESS: ____ (Same as above ☐)

EMPLOYER: _______________

CITY: __________________________ STATE: ______ ZIP: _________

PREFERRED PHONE #: (_________)_____________ Home / Work / Cell

OTHER PHONE #: (_________)________________ Home / Work / Cell

EMAIL (if preferred):

____

FINANCIAL AND INSURANCE INFORMATION:

PRIMARY DENTAL INSURANCE	
INSURANCE NAME	
INSURANCE PHONE #	
SUBSCRIBER NAME	
SUBSCRIBER ID	
SUBSCRIBER SSN	
SUBSCRIBER DOB	____ / ____ / ________
GROUP PLAN #	
ORTHO COVERAGE?	YES / NO / UNSURE

SECONDARY DENTAL INSURANCE	
INSURANCE NAME	
INSURANCE PHONE #	
SUBSCRIBER NAME	
SUBSCRIBER ID	
SUBSCRIBER SSN	
SUBSCRIBER DOB	____ / ____ / ________
GROUP PLAN #	
ORTHO COVERAGE?	YES / NO / UNSURE

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

Parent/Guardian Signature: ____________________________________ Date: ____/____/________

DENTAL HISTORY:

DENTIST NAME: ________________________________ LOCATION: __________________________ LAST VISIT: ____ / ____ / ________

City State

REASON FOR LAST VISIT: _______________________

HAS THE PATIENT EVER HAD AN ORTHODONTIC EXAM AND EVALUATION? YES / NO

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT THE PATIENT:

Question			Question		
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
Snoring or sleep apnea?	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	Regular brushing and flossing at home?	Y	N
Unusual change to face or bite?	Y	N	Is he/she cooperative at home?	Y	N
Gum disease?	Y	N	Previous orthodontic treatment?	Y	N

MEDICAL HISTORY:

PHYSICIAN NAME: _______________________________

IS THE PATIENT IN GOOD HEALTH? YES / NO

IS THE PATIENT CURRENTLY TAKING ANY MEDICATIONS? YES / NO

IF YES, PLEASE LIST MEDICATION AND CONDITION: ____

____

PLEASE LIST ALLERGIES TO ALL MEDICATIONS, FOODS, ETC: ____

____

DOES YOUR CHILD PRE-MEDICATE WITH ANTIBIOTICS FOR DENTAL PROCEDURES? YES / NO

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT THE PATIENT:

Question			Question		
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

DOES THE PATIENT 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 child's medical or dental health.

Parent/Guardian Signature: ____ Date: ____/____/________