CHILD MEDICAL AND DENTAL HISTORY

PATIENT INFORMATION:

TODAY'S DATE: ____ / ____ / _____

_____
First MI Last

AGE: _____

DOB: ____ / ____ / _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

MALE: ☐

FEMALE: ☐

OTHER: ☐

SIBLINGS NAMES / AGES: _____

SCHOOL: _____

If you prefer specific pronouns, please indicate here: _____

PARENT/GUARDIAN INFORMATION:

MOTHER: _____
First MI Last

PREFERRED PHONE #: (_____)_____ Home / Work / Cell

IF SAME AS CHILD, MARK THIS BOX ☐

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

MARITAL STATUS: _____

EMAIL: _____

EMPLOYER: _____

FATHER: _____
First MI Last

PREFERRED PHONE #: (_____)_____ Home / Work / Cell

IF SAME AS CHILD, MARK THIS BOX ☐

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

MARITAL STATUS: _____

EMAIL: _____

EMPLOYER: _____

IF APPLICABLE:

LIST ANY OTHER LEGAL GUARDIANS OF PATIENT (i.e. step-parent, grandparent, etc.): _____

FINANCIAL AND INSURANCE INFORMATION:

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

SECONDARY DENTAL INSURANCE	
INSURANCE NAME	
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 MO / YEAR

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT THE PATIENT:

Clenching/Grinding of teeth?	Y	N
Thumb/Finger sucking habit?	Y	N
Tongue thrust habit?	Y	N
Snoring or sleep apnea?	Y	N
Mouth breathing or trouble breathing through nose?	Y	N
Gum disease?	Y	N
Unusual change to face or bite?	Y	N

Injury to face, mouth, teeth or chin?	Y	N
Speech problems?	Y	N
Jaw joint problems or soreness in TMJ?	Y	N
Chipped teeth?	Y	N
Late erupting or missing adult teeth?	Y	N
Problems cooperating/tolerating dental work?	Y	N
Previous orthodontic treatment?	Y	N

WHY ARE YOU SEEKING ORTHODONTIC TREATMENT (MAIN CONCERN)? _____

INTERESTED IN (please circle): BRACES - CLEAR BRACES - INVISALIGN - EXPANDER/EARLY TREATMENT - RETAINERS ONLY

HOW DID YOU HEAR ABOUT US? _____

MEDICAL HISTORY:

PHYSICIAN NAME: _____ LOCATION: _____

IS THE PATIENT CURRENTLY TAKING ANY MEDICATIONS? YES / NO

IF YES, LIST ***MEDICATION AND CONDITION***: _____

_____

LIST ALL ***ALLERGIES*** (MEDICATION / LATEX / METALS / FOOD.): _____

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

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT THE PATIENT:

Allergy to latex / metal / local anesthetics?	Y	N
ADHD?	Y	N
Autism spectrum disorder?	Y	N
Cancer, tumor, radiation treatment, or chemotherapy?	Y	N
Skin problems?	Y	N
Neurological problems, migraines, seizures, epilepsy?	Y	N
Eyes / Ears / Nose / Throat problems?	Y	N
Tonsils/adenoids removed?	Y	N
Genetic or hereditary problems?	Y	N
Endocrine problems, diabetes, thyroid problems?	Y	N

Respiratory problems, asthma, TB?	Y	N
Cardiovascular problems, heart problems, murmurs, blood pressure, heart defect?	Y	N
Gastrointestinal/liver problems, hepatitis?	Y	N
Kidney problems?	Y	N
Musculoskeletal problems, arthritis, injuries?	Y	N
Immunologic problems, influenza, HIV/AIDS?	Y	N
Herpes, syphilis, gonorrhea?	Y	N
Cleft lip/palate?	Y	N
Eating disorders, anorexia, bulimia?	Y	N
Mental health problems, depression?	Y	N

IF "YES" TO ABOVE QUESTIONS, PLEASE SPECIFY: _____

DOES THE PATIENT HAVE ANY MEDICAL PROBLEM NOT LISTED ABOVE? _____

SIGNATURE:

I authorize Zach Frazier Orthodontics to take any necessary orthodontic records (x-rays, photos, 3D digital scans) to properly diagnose and plan my child's treatment.

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: ____/____/_____

ZACH FRAZIER ORTHODONTICS PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your protected health information (i.e. individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic date) may be used or disclosed by us, electronically or physically, in one or more of the following respects:

- To other healthcare providers (i.e. general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you; To third party payors or spouses (i.e. Insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account; To certifying, licensing and accrediting bodies (i.e. American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure, or accreditation; Internally, to all staff members who have any role in your treatment; To business associates (accountants, consultants, attorneys) who provide services and functions to our business; To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.; To other patients, or prospective patients, in print or electronic form for marketing purposes, limited to photos, first names, ages, and basic treatment information; To your family and close friends involved in your treatment; We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you; To law enforcement under specific circumstances; To government authorities in suspected cases of neglect/abuse or public health considerations or national security purposes; Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions in the use and disclosure of your protected health information (PHI); Request confidential communication of your PHI; Inspect and obtain copies of your PHI through asking us; Amend or modify your PHI in certain circumstances; Receive an accounting of certain disclosures made by us of your PHI; and, You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or in the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information (PHI)and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information; To abide by the terms of our Privacy Notice that is currently in effect; and, To advise you of your right to change the terms of the Privacy Notice and to make the new notice provisions effective for all PHI maintained by us, and that if we do so, we will make available to you a copy of the revised Privacy Notice.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your PHI; Amend your PHI if, for example, it is accurate and complete; or Provide an atmosphere that is totally free of the possibility that your PHI may be incidentally overheard by other patients or third parties.
- This Privacy Notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask our Privacy Contact Person or direct your questions to that person at our office address. Thank you.

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

_____ Patient/Parent/Guardian _____ Date

ZACH FRAZIER ORTHODONTICS

4909 FOREST AVENUE

DOWNERS GROVE, IL 60515

HIPAA MEDICAL AND DENTAL INFORMATION RELEASE FORM

PATIENT NAME: _____ PATIENT DATE OF BIRTH: ____ / ____ / _____

In some instances, family members who are involved in the care of the patient may attend appointments (For example, grandparents or aunts/uncles). If you wish for Dr. Zach Frazier to share protected health information (PHI), you must sign this form.

Protected health information includes:

- Diagnosis
- Treatment plans
- Treatment progress
- Appointment scheduling and information
- Treatment recommendations
- Any other information regarding treatment

I authorize Dr. Zach Frazier to share protected health information (PHI), including appointment information, diagnosis, treatment plans, treatment progression, and any other information relating to the treatment of the patient name above, with the following people:

*PLEASE NOTE: **MINOR PATIENTS (under 18)** – parents and legal guardians are already authorized to get health information.*

*PLEASE NOTE: **ADULT PATIENTS (over 18)** – if you authorize our office to share information with your parents for treatment or payment purposes, you must put their names below:*

NAME	RELATION TO PATIENT

I understand that communication may be done in person, over the phone, or electronically with any of the authorized people named above. By signing this form, I grant permission for Dr. Zach Frazier to share protected health information.

PATIENT / PARENT / LEGAL GUARDIAN SIGNATURE: _____

DATE: ____ / ____ / _____

☐ Check here if you do not authorize the release of my PHI to any other person.