ZACH FRAZIER ORTHODONTICS

CHILD MEDICAL AND DENTAL HISTORY

PATIENT INFORMATION:

TODAY'S DATE: ____ / ____ / ______

____
First MI Last

STREET ADDRESS: ____ AGE: _________

CITY: ________________________ STATE: ______ ZIP: __________ DOB: ____ / ____ / ______

MALE: ☐

SIBLINGS NAMES / AGES: _____________________________________ FEMALE: ☐

SCHOOL: _______________________

PARENT/GUARDIAN INFORMATION:

MOTHER: ____
First MI Last

MARITAL STATUS: __________

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

EMAIL: ____________________________________

IF SAME AS CHILD, MARK THIS BOX

STREET ADDRESS: ____ EMPLOYER: _______________________

CITY: ________________________ STATE: ______ ZIP: __________

FATHER: ____
First MI Last

MARITAL STATUS: __________

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

EMAIL: ____________________________________

IF SAME AS CHILD, MARK THIS BOX

STREET ADDRESS: ____ EMPLOYER: _______________________

CITY: ________________________ STATE: ______ ZIP: __________

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: ____/____/_______

V12.2021

DENTAL HISTORY:

DENTIST NAME: ______________________________ LOCATION: ________________________ LAST VISIT: ____ / ________

City State MO / YEAR

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT THE PATIENT:

Question	Y	N	Question	Y	N
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
Gum disease?	Y	N	Problems cooperating/tolerating dental work?	Y	N
Unusual change to face or bite?	Y	N	Previous orthodontic treatment?	Y	N

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

INTERESTED IN (please circle): BRACES CLEAR BRACES INVISALIGN EARLY TREATMENT / EXPANDER OTHER

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/FOOD/ETC.): ____

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

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT THE PATIENT:

Question	Y	N	Question	Y	N
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, etc.)?	Y	N	Gastrointestinal/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

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

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: ____/____/________