Debra Z. Alavi Date______________________________
15927 South Bell Road
Homer Glen, IL 60491

Patients
Name____Birthday_________________________Age____________________
Address____ Phone (______)_____________________________Gender M/F

City____________________________State___________Zip____________School_________________________________grade______

Father's Name______________________________Birthday_____________________Soc.Sec.No.____________________________

Mother's Name ____________________________Birthday _____________________Soc/Sec.No. ___________________________

Parent's Marital Status: Married Divorced Seperated Widowed other:__________________________

Person Responsible for Account _________________________________ Address ____

Name of General Dentist _________________________ Names of Other Family Members Treated Here _____________________

Main Concern ____How were you referred to this office? ____________________

ORTHODONTIC INSURANCE:

PRIMARY

Insurance Co. Name _____________________________________

Group # ____

Insured's Name ____

Insured's Employer _______________________________________

SECONDARY

Insurance Co. Name ______________________________________

Group # ____

Insured's Name ____

Insured's Employer _______________________________________

Describe your child's health: GOOD FAIR POOR List any drug allergies: ______________________________

List all drugs currently being taken:

____

Child's Physician: __________________________________ Phone #: (________)_____________________ Last Visit: ___________

Is your child under the care of a physician?................................Y N
Has your child ever had orthodontic treatment?..........................Y N
Have there been injuries to the face, mouth, teeth, chin?............Y N
Have tonsils/adenoids been removed?.......................................Y N
Does your child have any missing or extra permanent teeth?.....Y N
Any tenderness in the jaw joint (TMJ)?.....................................Y N
Does your child brush daily?..Y N
Has puberty begun?..Y N

Habits?
Clenching/Grinding………………………Y N
Mouth Breathing…………………………..Y N
Nail Biting………………………………...Y N
Speech Problems…………………………Y N
Thumb/finger habit………………………..Y N
Tongue Thrust……………………………Y N
Has menstruation begun?..........................Y N

Abnormal Bleeding Y N Asthma Y N Tuberculosis Y N ADD/ADHD Y N
Allergy to Plastic Y N Cancer Y N Heart Murmur Y N Hearing Impairment Y N
Allery to any Drugs Y N Hemophilia Y N Hepatitis Y N HIV+/AIDS Y N
Allergy to Latex Y N Diabetes Y N Allergy to Metals Y N Hospital Stays Y N
Congenital Heart Defect Y N Rheumatic/Scarlet Fever Y N Convulsions/Epilepsy Y N
Handicaps/Disabilities Y N Any operations Y N Please discuss any medical problems: __________________

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I understand that the information that I have provided is correct to the best of my knowledge, and that it will be held in the strictest confidence. It is my responsibility to inform the office of any changes in my child's medical status.

This office reserves the right to verify the credit status of potential patients and/or parents of patients, prior to extending credit for treatment fees, and may use the services of one or more credit reporting services.

____ ___________________________

Parent or Guardian Signature Date