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

Date ______________ Exam with ______________
FMXR BW Disposition ______________
PA's ________ MOGO # ______________
none ________

Patient Name______________________________ Birthdate______________ Age________
Address______________________________ Phone(___)________ Gender________
City__________________ State______ Zip________ School__________________ Grade________
Father's Name______________________________ Birthdate______________
Father's Address (if different from above)______________________________
Father's Employer__________________ Work # (___)__________ Soc.Sec.No.__________
Mother's Name______________________________ Birthdate______________
Mother's Address (if different from above)______________________________
Mother's Employer__________________ Work # (___)__________ Soc.Sec.No.__________
Parent's Marital Status: Married Separated Divorced 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	Secondary
Insurance Co. Name__________	Insurance Co. Name__________
Group # (Plan, Local or Policy #)__________	Group # (Plan, Local or Policy #)__________
Insured's Name__________	Insured's Name__________
Insured's Employer__________	Insured's Employer__________

Describe your childs health: Good Fair Poor
List all drugs currently being taken______________________________
List any drug allergies______________________________
Child's Physician: __________________ Phone # (___)__________ Last visit:__________

			Habits?
Is your child under the care of a Physician?..............................	Y N		
Has your child ever had orthodontic treatment?............................	Y N	Y N	Clenching/grinding teeth
Have there been injuries to the face, mouth, teeth chin?..............	Y N	Y N	Mouth breathing
Have tonsils/ adenoids been removed?..	Y N	Y N	Nail biting
Does your child have any missing or extra permanent teeth?...	Y N	Y N	Speech problems
Any tenderness in the jaw joint (TMJ)?..	Y N	Y N	Thumb/finger habit
Does your child brush daily?..	Y N	Y N	Tongue thrust
Has puberty begun?..	Y N		__________
Has menstruation begun (girls)..	Y N	Y N	Tuberculosis (TB)

Y N	Abormal Bleeding	Y N	Asthma	Y N	Hearing Impairment
Y N	Allergic to Plastic	Y N	Attention Deficit Disorder	Y N	Heart Murmur
Y N	Allergies to any Drugs	Y N	Cancer	Y N	Hemophilia
Y N	Allergy to Latex/Metals	Y N	Congenital Heart Defect	Y N	Hepatitis
Y N	Speech Problems	Y N	Convulsions/Epilepsy	Y N	HIV+/ AIDS
Y N	Any Hospital Stays	Y N	Diabetes	Y N	Kidney/Liver Problems
Y N	Any Operations	Y N	Handicaps/Disabilities	Y N	Rheumatic/ Scarlet Fever

Please discuss any medical problem:______________________________
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I understand that the information that I have given is correct to the best of my knowledge and that it will be held in the strictest confidence. It is my resposibility 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/Guardian Date Parent/Guardian Date