ZAIDI orthodontics

Sheeba N. Zaidi, D.M.D

Welcome to Zaidi Orthodontics! We are committed to providing you with the highest quality of orthodontic care.

1. ABOUT YOU

Today's Date: _____
E-Mail: _____
Name: _____
Last First MI
I prefer to be called: _____ □ Male □ Female
Birthdate: ____/____/____ Age: _____
SS#: _____
Home Address: _____ Apt # _____
_____
City State Zip Code
□ Single □ Married □ Divorced
□ Widowed □ Separated
Home #: _____ Cell #: _____
Work #: _____ Ext._____
Employer: _____
Whom may we thank for referring you?
_____
Other family members seen by us:
_____
General Dentist: _____
Last visit date: _____

2. SPOUSE INFORMATION

His /Her Name: _____
Employer: _____
Work #: _____ Ext: _____
Cell #:_____ SS#: _____
Birthdate: ____/____/____ Email: _____

3. Person Responsible for Account:

Name: _____
Home #: _____
Work #: _____ Ext. ___
Billing Address: _____
Relation: _____ SS #: _____
Employer: _____
Self: □ Yes □ No Email: _____

4. ORTHODONTIC INSURANCE

PRIMARY

Orthodontic Coverage: □ Yes □ No
Dental Coverage: □ Yes □ No
Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Co. Phone #: _____
Group#: _____
ID#: _____
Insured's Name: _____
Relation: _____
Insured's Birthdate: ___/___/___
Insured's ID #: _____
Insured's Employer: _____

SECONDARY

Orthodontic Coverage: □ Yes □ No
Dental Coverage: □ Yes □ No
Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Co. Phone #: _____
Group#: _____
ID#: _____
Insured's Name: _____
Relation: _____
Insured's Birthdate: ___/___/___

In the event of an emergency, is there someone who lives near you that we should contact?

His /Her Name: _____
Relation: _____
Home Phone #: _____
Work #: _____ Ext: ____

5. MEDICAL HISTORY

Do you have a personal physician? □ Yes □ No
Physician's Name: _____
Phone #: _____
Date of last visit: _____

5. MEDICAL HISTORY continued

Your current physical health is: □Good □Fair □Poor

Are you currently under the care of a physician? □Yes □No

Please explain: _____

Are you taking prescription/over the counter drugs? □ Yes □ No

Please list each one: _____

_____

Are you using a prescribed method of birth control? □Yes □No

Are you pregnant? □Yes □No Week #_____

Are you nursing? □Yes □No

Have you ever had any of the following diseases or medical problems?

Y N	Abnormal Bleeding	Y N	Hemophilia
Y N	Anemia	Y N	Hepatitis
Y N	Artificial Bones/ Joints/Valves	Y N	High/ Low Blood Pressure
Y N	Asthma	Y N	Arthritis
Y N	HIV+ /AIDs	Y N	Blood Transfusion
Y N	Hospitalized for Any Reason	Y N	Cancer/ Chemotherapy
Y N	Kidney Problems	Y N	Congenital Heart Failure
Y N	Mitral Valve Prolapse	Y N	Diabetes
Y N	Psychiatric Problems	Y N	Difficulty Breathing
Y N	Radiation Treatment	Y N	Drug/ Alcohol Abuse
Y N	Rheumatic / Scarlet Fever	Y N	Emphysema
Y N	Severe/Frequent Headaches	Y N	Epilepsy/Seizures/Fainting
Y N	Shingles	Y N	Fever Blisters/ Blisters
Y N	Sickle Cell Disease/ Traits	Y N	Glaucoma
Y N	Sinus Problems	Y N	Heart Attack/ Stroke
Y N	Tuberculosis (TB)	Y N	Heart Murmur
Y N	Ulcers / Colitis	Y N	Heart Surgery / Pacemaker
Y N	Venereal Disease		

Please list any serious medical condition(s) that you have ever had:

_____

Are you allergic to any of the following?

Y N	Aspirin	Y N	Dental Anesthetics	Y N	Penicillin
Y N	Any Metals/Plastics	Y N	Erythromycin	Y N	Tetracycline
Y N	Codeine	Y N	Latex	Y N	Other

Please list any other drugs/materials that you are allergic to: _____

_____

6. DENTAL HISTORY

What are the main concerns that you would like orthodontics to accomplish?

_____

_____

_____

Have you ever had or been evaluated for orthodontic treatment? □ Y □ N

Have you ever had a serious/ difficult problem associated with any previous dental work? □ Y □ N

Do you now or have you ever experienced pain/ discomfort in your jaw joint (TMJ/TMD)? □ Y □ N

Your current dental health is: □ Good □ Fair □ Poor

Do you take medication before dental visits? □Y □ N

Do you like your smile? □ Y □ N

Gums ever Bleed □ Y □ N

Have you ever had an injury to your:

□ Mouth □Teeth □Chin

Do you have any speech problems? □ Y □ N

Do you generally breathe through your mouth? □ Y □ N

If Yes, please circle: While Awake? While Asleep?

Do you have any missing or extra permanent teeth? □ Y □ N

Have you ever taken Fosamax, or any other Bisphosphonate? □ Y □ N

Have you ever taken Phen-Fen? □ Y □ N

Do you smoke or use tobacco in any form? □ Y □ N

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

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

_____

Signature of patient Date

Our office is Hippa Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

_____