

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

1. TELL US ABOUT YOUR CHILD

Today's Date: ___/___/___ ☐ Male ☐ Female

Child's Name: _____
Last First MI

Nickname: _____

Child's Birthdate: _____ Child's Age: _____

School: _____ Grade: _____

Hobbies /Sports: _____

Child's Home #: _____

Child's Home Address: _____

City State Zip Code

Email: _____

Child's Dentist: _____

4. PERSON RESPONSIBLE FOR ACCOUNT

☐ Same as Parent's Information

Name: _____

Relation: _____

Billing Address: _____

City State Zip Code

Home#: _____

Cell#: _____

Employer: _____

Work#: _____ Ext: _____

SS#: _____ Email: _____

5. INSURANCE INFORMATION

PRIMARY

Coverage: Ortho: ☐ Yes ☐ No

Dental: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group #: _____

ID #: _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___

Policy Owner's Employer: _____

SECONDARY

Coverage: Ortho: ☐ Yes ☐ No

Dental: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group #: _____

ID #: _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___

Policy Owner's Employer: _____

2. WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: _____

Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we thank for referring you?

Siblings w/Age: _____

Last Visit Date: _____

Parent's Marital Status: ☐ Single ☐ Widowed

☐ Married ☐ Divorced ☐ Separated

3. PARENT'S INFORMATION

☐ Mother's Information: ☐ Stepmother ☐ Guardian

Name: _____ Birthdate: ___/___/___

Home #: _____ Cell #: _____

Work #: _____ Ext. _____

Employer: _____

How long at current job? _____ Job Title: _____

SS#: _____ Email: _____

☐ Father's Information: ☐ Stepfather ☐ Guardian

Name: _____ Birthdate: ___/___/___

Home #: _____ Cell #: _____

Work #: _____ Ext. _____

Employer: _____

How long at current job? _____ Job Title: _____

SS#: _____ Email: _____

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

Has your child ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

Has there been any injuries to the face, mouth, teeth or chin? ☐ Yes ☐ No

List any musical instruments played: _____

Have adenoids or tonsils been removed? ☐ Yes ☐ No

Does your child snore? ☐ Yes ☐ No

Has your child been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Has your child ever had any pain / tenderness in their jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Does your child brush his/her teeth daily? ☐ Yes ☐ No

What is your child's current height? _____ FT _____ IN

Has puberty begun? ☐ Yes ☐ No

Has menstruation begun? (Girl) ☐ Yes ☐ No

Has voice changed? (boy) ☐ Yes ☐ No

7. Does your child have any of the following habits?

Y N Clenching / Grinding Teeth	Y N Pacifier Use
Y N Lip Sucking / Biting	Y N Speech Problems
Y N Mouth Breather	Y N Tongue Thrust
Y N Thumb /Finger Sucking	Y N Nail Biting

8. Has your child ever had any of the following medical problems?

Y N Handicaps / Disabilities	Y N Abnormal Bleeding
Y N ADD / ADHD	Y N Hearing Impairment
Y N Allergies to any Drugs	Y N Heart Murmur
Y N Allergic to Latex / Metals	Y N Hemophilia
Y N Allergic to Plastic	Y N Hepatitis
Y N Any Hospital Stays	Y N HIV+ / AIDS
Y N Any Operations	Y N Kidney Problems
Y N Liver Problems	Y N Asthma
Y N Lupus	Y N Cancer
Y N Convulsions / Epilepsy	Y N Tuberculosis (TB)
Y N Sickle Cell Disease / Traits	Y N Diabetes
Y N Congenital Heart Defect	
Y N Rheumatic /Scarlet Fever	
Y N Artificial Bones/Joints/Valves	

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

Is your child currently under the care of a physician? ☐ Yes ☐ No

Has your child ever taken Phen-Fen? ☐ Yes ☐ No
(also known as Redux or Pondimin)

If Yes, when? _____

Please describe your child's current physical health:
☐ Good ☐ Fair ☐ Poor

Please list all drugs that your child is currently taking:

Does your child take medication before dental visits? ☐ Yes ☐ No

Please list all the drugs/things that your child is allergic to: _____

Please discuss any medical problems that your child has had: _____

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 parent or guardian

Date

The Parent or Guardian who accompanies the child is responsible for payment.

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.

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

Doctor's Comments: _____