Zaidi ORTHODONTIX

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Welcome to Zaidi Orthodontix! 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: _____

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: _____

_____

General Dentist: _____

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#: _____

_____

□ **Father's Information:** □ Stepfather □ Guardian

Name: _____Birthdate: ___/___/___

Home #: _____Cell #: _____

Work #: _____Ext. _____

Employer: _____

How long at current job? _____ Job Title: _____

SS#: _____

4. PERSON RESPONSIBLE FOR ACCOUNT

□ **Same as Parent's Information**

Name: _____

Relation: _____

Billing Address: _____

_____
City State Zip Code

Home#: _____

Cell#: _____

Employer: _____

Work#: _____ Ext: _____

SS#: _____

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: _____

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

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

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

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:

_____

_____

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.

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/parent/guardian named herein. Initials: _____ Date: _____

Doctor's Comments: _____

_____

_____