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# Zaki Orthodontics

"We specialize in beautiful smiles and faces"

ABO BOARD CERTIFIED AMERICAN BOARD OF ORTHODONTICS EST. 1929

## PATIENT INFORMATION

Date________________________________

Patient's Name ______________________________________ Nickname ______________ Sex Female ( ) Male ( )

Age ________ Birthdate ______/______/______ SS# ________________________________________

Address ____________________________________________________________________________ Zip ______________

Phone: Home ___________________________ Cell _________________________ Work _______________________

Email Address ___________________________________________________ Marital Status _______________________

Dental Insurance ( ) Yes ( ) No Orthodontic Coverage ( ) Yes ( ) No ( ) Unsure

Patient's Insurance Company & Phone # __________________________________________ Group # ______________

Employer's Name and Address ___________________________________________________________________________

Dentist ________________________________________________ Date of last dental visit _______________________

Physician _____________________________________________ Hobbies & Interests ___________________________

Whom may we thank for referring you? _____________________________________________________________________

## FAMILY INFORMATION

Spouse's Name _________________ Birthdate ____/____/____ SS# _________________ Phone # ____________

Employer's Name and Address ___________________________________________________________________________

Dental Insurance ( ) Yes ( ) No Orthodontic Coverage ( ) Yes ( ) No ( ) Unsure

Insurance Company & Phone # ____________________________________________ Group # ___________________

Name of person, not related, to call in case of emergency __________________________ Phone # ______________

Note any other additional insurance coverage: ____________________________________________________________

__________________________________________________________________________________________________

## AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. If my insurance is accepted in Dr. Zaki's office, I authorize and request my insurance company to pay directly to Tarek O. Zaki, DDS insurance benefits otherwise payable to me, which are hereby assigned irrevocably to Tarek O. Zaki, DDS. I authorize Tarek O. Zaki, DDS to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for and promise to pay within thirty (30) days of billing all charges not paid by insurance. I authorize the use of this signature on all insurance submissions. I understand there is a fee to duplicate records. Accounts which are 90 days or more in arrears will be sent to collections. Patient, parent or responsible party agrees to be responsible for all costs of collection, including but not limited to all attorney's fees and court costs.

__________________________________________________________________________

SIGNATURE OF RESPONSIBLE PARTY

## MEDICAL HISTORY

Please circle Yes or No

1. As far as you know, are you in good health? Y N
2. Do you have, or have you ever had any of the following: Rheumatic Fever, Heart Disease, Kidney Disease, Asthma, Blood Disease or Disorder, Heart Murmur, Joint Replacements, or any other medical problems? Y N

   If yes, please explain ____________________
3. Are you taking any medication at present? Y N

   If yes, please list medication, dose and reason ____________________
4. Do you have any allergies to food, medication, latex, or any metals; i.e., nickel? Y N

   If yes, please describe ____________________
5. Have you been hospitalized for any reason in the past 5 years? Y N

   If yes, please describe ____________________
6. Have you ever had a blood transfusion? Y N

   If yes, please describe ____________________
7. Would you consider yourself at high risk for Hepatitis or HIV infection? Y N
8. Females only: Are you pregnant? Y N Are you nursing? Y N

## DENTAL HISTORY

1. Have you ever had a severe face or jaw injury? Y N
2. Do you grind your teeth or clench your jaw? Y N
3. Have you ever had jaw pain or clicking? Y N
4. What is the main concern that brought you to our office today? ____________________

   ____________________
5. Have you ever had a prior orthodontic examination or treatment? Y N

   If yes, where and when? ____________________

   ____________________