Member American Association of Orthodontists®
My Life. My Smile. My Orthodontist.®

Zaki Orthodontics

"We specialize in beautiful smiles and faces"

PATIENT INFORMATION

Date_____

Patient's Name _____ Nickname _____

DOB _____/_____/_____ Sex ( ) F ( ) M Age _____

School Attended _____ Grade _____

Home Address _____ Zip _____

Dentist _____ Date of Last Dentist Visit _____

Physician _____ Other Family Members In Practice _____

Interests, Hobbies _____

Whom may we thank for referring you? _____

FAMILY INFORMATION

❑ Father ❑ Stepfather Name _____ SS# _____ DOB _____/_____/_____

Street Address _____ City _____ State _____ Zip _____

Phone: Home _____ Cell_____ Work _____ Email _____

Employer's Name and Address _____

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

Name & Phone of Insurance Company _____ Group # _____

❑ Mother ❑ Stepmother Name _____ SS# _____ DOB _____/_____/_____

Street Address _____ City _____ State _____ Zip _____

Phone: Home _____ Cell_____ Work _____ Email _____

Employer's Name and Address _____

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

Name & Phone of Insurance Company _____ Group # _____

Name of person to call in case of emergency _____ Phone # _____

Person(s) responsible for account (if different from above) Name _____ Relationship _____

Address _____ Phone _____ DOB____/____/____ SS# _____

IF YOUR CHILD IS COVERED BY ANY OTHER INSURANCE PLEASE LIST BELOW:

Insured's Name _____ SS# _____

Street Address _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Cell _____ Email _____

Name & Phone of Insurance Company _____

Employer's Name
and Address _____

MEDICAL HISTORY

Please circle Yes or No

1. As far as you know, is the child in good health? Y N
2. Did the child ever have any of the following: Rheumatic Fever, Heart Disease, Kidney Disease, Asthma, Blood Disease or Disorder, Heart Murmur, Joint Replacement, or any other medical problems? Y N
   If yes, please explain: _____
3. Is the child taking any medication at present? Y N
   If yes, please list medication, dose and reason _____
4. Does the child have any allergies to food, medication, latex, or any metals; i.e., nickel? Y N
   If yes, please describe _____
5. Has the child been hospitalized for any reason in the past 5 years? Y N
   If yes, please describe _____
6. Would you consider your child at high risk for Hepatitis or HIV infection? Y N
7. Any previous or current medical condition(s) that we should be aware of? Y N
   If yes, please describe _____
8. Adolescent Females only: Has menstruation begun? Y N
   If yes, approximate month and year _____ _____ Females only: Is patient pregnant? Y N

DENTAL HISTORY

1. Did the patient start teething very early or late? Y N
2. Has the patient ever had a severe face or jaw injury? Y N
3. Has the patient had tooth grinding or jaw clenching? Y N
4. Has the patient ever had jaw pain or clicking? Y N
5. What is the main concern that brought you to our office today? _____

   _____
6. Has the patient ever had a prior orthodontic examination or treatment? Y N

   If yes, where and when? _____

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