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 _____