WELCOME TO ZAHROWSKI ORTHODONTICS

PLEASE PRINT & COMPLETE BOTH FRONT & BACK

PATIENT'S NAME: _____ BIRTHDATE: _____ AGE in YRs: _____ MOs: _____

TODAY'S DATE: _____ SEX: _____ HEIGHT: _____ E-MAIL: _____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

YOUR INFORMATION

SOCIAL SECURITY #: _____ DOB: _____

➢ *Please check which number is the best to reach you during the day*

☐ HOME #: _____
☐ WORK #: _____
☐ CELL #: _____

EMPLOYED BY: _____

BUSINESS ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SPOUSE'S NAME: _____

SOCIAL SECURITY #: _____ DOB: _____

➢ *Please check which number is the best to reach you during the day*

☐ HOME #: _____
☐ WORK #: _____
☐ CELL #: _____

EMPLOYED BY: _____

BUSINESS ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOW WERE YOU REFERRED?

☐ DENTIST ☐ FAMILY ☐ FRIENDS
☐ DRIVE-BY ☐ WEBSITE ☐ INVISALIGN

☐ OTHER _____

↓ REFERRER'S FULL NAME

_____

PLEASE *CIRCLE* EITHER **YES** OR **NO** TO THE FOLLOWING:

YES NO - HAVE YOU EVER BEEN SEEN FOR ANY OTHER ORTHODONTIC CONSULTATION?

IF YES, WHO WAS THE ORTHODONTIST? _____ DATE: _____

YES NO - HAVE YOU EVER HAD PREVIOUS ORTHODONTIC TREATMENT?

WHO WAS THE ORTHODONTIST? _____ CITY: _____

YES NO - ***HAS ANYONE IN YOUR FAMILY HAD ORTHODONTIC TREAMENT IN OUR OFFICE?***

☐ BROTHER/SISTER ☐ MOM/DAD ☐ AUNT/UNCLE ☐ COUSIN ☐ OTHER_____

FAMILY MEMBER'S FIRST & LAST NAME: _____

PRIMARY INSURED INFORMATION

Name of Insured: _____

Insured's DOB: _____ Insured's SSN or ID: _____

Relationship to Patient: _____

Address of Insured: _____

City: _____ State: _____ Zip: _____

Employed by: _____

Work Address: _____

City: _____ State: _____ Zip: _____

Dental Ins Co. Name: _____

Ins Address: _____

City: _____ State: _____ Zip: _____

PRIMARY INSURED INFORMATION

Name of Insured: _____

Insured's DOB: _____ Insured's SSN or ID: _____

Relationship to Patient: _____

Address of Insured: _____

City: _____ State: _____ Zip: _____

Employed by: _____

Work Address: _____

City: _____ State: _____ Zip: _____

Dental Ins Co. Name: _____

Ins Address: _____

City: _____ State: _____ Zip: _____

FOR OFFICE USE ONLY

DIAG RECORDS: $ _____
TREATMENT FEE: $ _____
INSURANCE: $ _____
PERSONAL: $ _____

DOWN PMT: $ _____

MONTHLY PMTS: $ _____

Full Treatment:
- Non-Extraction
- Extraction
- MSI
- Surgery

Phase I
Limited
Retainers

Appliance(s):
U – TYPE: Metal Clear Aligner
L – TYPE: Metal Clear Aligner

Model #: _____

PATIENT'S DENTAL HISTORY

PATIENT'S NAME: _____ LAST DENTAL APPT: _____

DENTIST'S NAME: FIRST: _____ LAST: _____ Phone: _____

DENTIST'S ADDRESS: _____ CITY: _____ ZIP: _____

PLEASE CHECK REASONS FOR SEEKING AN ORTHODONTIC CONSULTATION:

☐ FRONT TEETH PROTRUDING ☐ CROWDED TEETH ☐ SPACES BETWEEN TEETH

☐ OVERBITE/UNDERBITE ☐ JAW/JOINT PAIN ☐ OTHER _____

*PLEASE CIRCLE EITHER **YES** OR **NO** TO THE FOLLOWING*:

YES NO – Did your dentist encourage you to seek this consultation?
YES NO – Do you have pain from your teeth, oral tissue, or face?
YES NO – Have you had gum problems or received periodontal treatment?
YES NO – Have you had cavities filled by your dentist in last 3 years? #: __
YES NO – Do you have any missing or extra teeth?
YES NO – Have you ever had any difficulty with past dental treatments?
YES NO – Have you ever had trouble opening your mouth wide?
YES NO – Do your jaws ever click or pop?
YES NO – Do you have pain while chewing or have had TMJ problems?
YES NO – Have you had an injury to your face, neck, jaws, or teeth? Explain: _____

CHECK HABITS:

☐ Thumb/Finger Sucking ☐ Pacifier
☐ Fingernail Biting ☐ Object Biting (pencil, etc.)
☐ Tooth Grinding ☐ Mouth Breathing
☐ Other _____

What Are You Interested In: ☐ Invisalign ☐ Mini (metal) Braces ☐ Clear (ceramic) Braces ☐ Retainers

PLEASE INDICATE YOUR CONCERNS ABOUT THE FOLLOWING:

YES NO – FEAR OF PAIN YES NO – TRUST IN DENTISTS YES NO – FEAR OF DENTISTS
YES NO – FINANCIAL CONCERNS YES NO – WANTS TREATMENT YES NO – OUTSIDE CONFLICTS

PATIENT'S MEDICAL HISTORY

It is required by law that we have a complete medical history for all of our patients.
Please answer the following questions as accurately as possible.

PLEASE CIRCLE EITHER YES OR NO TO THE FOLLOWING MEDICAL INFORMATION:

YES NO – Have you been a patient in a hospital during the past 5 years?
YES NO – Are you currently being treated by your physician?
YES NO – Are you taking any kind of medicine or drugs? **Please list ALL MEDS →**
YES NO – Are you currently or have you taken **Bisphosphonates** (Fosamax or Alendronate, Actonel, Boniva, Reclast, Zometa, or Aredia) or **Denosumab** (Prolia, Xgeva)?
YES NO – Do you smoke or use tobacco products? How much? _____
YES NO – Do you suffer from frequent or severe headaches, neck, or back pain?

PLEASE LIST ALL MEDICATION(S) THE PATIENT IS PRESENTLY ON OR HAS TAKEN IN THE PAST YEAR:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Are you allergic to any of the following?

YES NO – Latex YES NO – Any Metals/Plastic YES NO – Acetaminophen (Tylenol)
YES NO – Penicillin YES NO – Aspirin YES NO – Ibuprofen (Advil, Motrin)
YES NO – Codeine YES NO – Dental Anesthetics (Benzocaine, Lidocaine)

Please list any other allergies _____

Physician's Name: _____

Address: _____ City: _____ Phone: _____

FEMALES ONLY:

YES NO - Is there a possibility you may be pregnant?
YES NO - Are you pregnant?
How many months? _____
YES NO - Are you nursing?

Have you ever had any of the following diseases or medical conditions? *You must circle either Y or N*

Y N Abnormal Bleeding
Y N AIDS/HIV+
Y N Anemia
Y N Artificial Heart Valve
Y N Artificial Joints or Bones
Y N Arthritis/Painful Joints
Y N Asthma
Y N Breathing Problem during Sleep
Y N Cancer or Chemotherapy
Y N Chest Pain upon Exertion
Y N Congenital Heart Defects
Y N Cyanotic (blue skin/tissue)
Y N Diabetes
Y N Dizziness/Fainting/Seizures
Y N Drug/Alcohol Abuse
Y N Emphysema/Bronchitis
Y N Endocarditis
Y N Heart Attack/Stroke/TIA
Y N Heart Valves Damaged
Y N Heart Pacemaker
Y N Heart or Organ Transplant
Y N Hemophilia
Y N Hepatitis
Y N High/Low Blood Pressure
Y N Kidney/Liver Problems
Y N Osteogenesis Imperfecta
Y N Osteoporosis
Y N Persistent Cough/Swollen Glands
Y N Psychiatric Treatment
Y N Radiation Treatment
Y N Sexually Transmitted Disease
Y N Sinus Problems
Y N Steroid Chronic Use (prednisone)
Y N Stomach/Intestinal Problems
Y N Thyroid Problem/Treatment
Y N Tuberculosis

Other diseases or conditions not listed you think I should know _____

To the best of my ability, all the information that I have provided on this form is accurate and current. In addition, I have given permission for Zahrowski Orthodontics to use my email address for correspondence by including it on this form.

Reviewed by Dr. Zahrowski
Signature _____
Date _____

X SIGNATURE OF PATIENT _____ Date: _____