# Zaher Aymach D.D.S.

DIPLOMATE OF THE AMERICAN BOARD OF ORTHODONTICS

ORTHODONTICS FOR CHILDREN, ADOLESCENTS & ADULTS

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The following information is requested to enable us to give you the best consideration of your orthodontic problem during your initial examination in our office. In order for us to thoroughly diagnose any condition, we must have the accurate background and health information on which to base our decisions. This information, which is important for our records and your health, is **confidential.**

## PATIENT INFORMATION

Patient's Name: _____ Birth date: _____ Sex: _____
Home Address: _____
Home Phone: _____ Mobile / Work Phone: _____
Employer or School: _____
Person Responsible for Account: ❒ Self ❒ Father ❒ Mother ❒ Guardian ❒ Other: _____
Is patient covered by insurance for orthodontic treatment? ❒ Yes ❒ No
If YES, by which company? _____ SSN # of the insured: _____
Family Dentist: _____ Phone #: _____
Family Physician: _____ Phone #: _____

## FAMILY HISTORY

Father's Name _____ Living? ❒ Yes ❒ No
Mother's Name _____ Living? ❒ Yes ❒ No
Siblings: ❒ None _____ Number of Brothers _____ Number of Sisters
Patient is living with: ❒ Mother ❒ Father ❒ Spouse ❒ Self ❒ Other: _____
If Applicable, Spouse's Name: _____

## MEDICAL HISTORY (confidential)

*Has the patient ever had:*

❒ Asthma ❒ Anemia ❒ Blood Disease ❒ Bone Disorders ❒ Hearing Disorder
❒ Diabetes ❒ Epilepsy ❒ Endocrine Problems ❒ Emotional Problems ❒ Head or Face Injury
❒ Herpes ❒ Hepatitis B ❒ Hepatitis C ❒ HIV ❒ Rheumatic Fever ❒ Other (describe below)
Comments: _____

Has the patient been under the care of a physician during the past two years, other than for routine examination? ❒ Yes ❒ No If yes, condition: _____
Present drugs or medication: _____
Birth Defects: _____
Has the patient reached puberty (menstruation, hair)? ❒ Yes ❒ No

## RESPIRATORY HISTORY

Does the patient:

1. Have allergies to: ❒ Seasonal grasses _____ ❒ Food _____
   ❒ Drugs _____ ❒ Other _____
2. Snore when sleeping? ❒ Yes ❒ No
3. Breathe through mouth? ❒ Seldom ❒ Sometimes ❒ Usually ❒ Never
4. Have frequent colds? ❒ Yes ❒ No
5. Have frequent "stuffy nose"? ❒ Yes ❒ No
6. Have frequent sore throat or tonsillitis? ❒ Yes ❒ No
7. Have chewing or swallowing difficulty? ❒ Yes ❒ No

Has the patient received medical treatment from allergist or ear, nose, and throat specialist? ❒ Yes ❒ No

If yes: When? _____ By Whom? _____

Nasal Surgery: ❒ Yes ❒ No Tonsils Removed: ❒ Yes ❒ No Adenoids Removed: ❒ Yes ❒ No

## DENTAL HISTORY

Does the patient have pain or clicking in jaw joint? ❒ Yes ❒ No

Have any teeth been injured due to accidents or blows to the mouth? ❒ Yes ❒ No

Has the patient received or been requested to receive speech correction? ❒ Yes ❒ No

The following habits are of interest. List information as it pertains to patient:

Thumb sucking until age: _____ Grinding of teeth ❒ Yes ❒ No

Finger sucking until age: _____ Tongue thrusting ❒ Yes ❒ No

Lip-biting or sucking: ❒ Yes ❒ No Other habits: _____

Has the patient had any unusual dental experiences? ❒ Yes ❒ No

If yes, please specify: _____

Date of last dental check-up: _____ Were the patient's teeth cleaned? ❒ Yes ❒ No

## ORTHODONTIC HISTORY

Has the patient had previous orthodontic ❒ consultation or ❒ treatment? ❒ Yes ❒ No

Date: _____ Doctor: _____

Orthodontic consultation prompted by: ❒ Patient ❒ Dentist ❒ Parents ❒ Physician ❒ Other: _____

Patient's interest in orthodontic treatment:

❒ Wants Treatment ❒ Treatment if Necessary ❒ Unwilling by Agree ❒ Uncooperative

Why did patient seek this treatment/consultation? _____

What is the primary problem? _____

Are you interested to start treatment today? _____

Additional comments you wish to make: _____

_____

● I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

● Our policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with the office. If account in not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, interest charges, and any other expenses incurred in collecting your account.

● I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

SIGNATURE (OF PERSON COMPLETING THIS FORM): _____ DATE: _____

NAME PRINTED : _____ RELATIONSHIP TO PATIENT: _____