Welcome to Zirbel Orthodontics

Cassandra L. Zirbel, D.D.S., M.S.

We would like to welcome you to our office. Our goal is to make every visit pleasant and educational.
Please fill out the following information to assist us with your care and enhance customer service.

How did you hear about us?

❑ Family member(s) are patients or had treatment at this office - Name and relation:_____

❑ Friends are patients or had treatment at this office - Whom may we acknowledge?_____

❑ Referred by Dentist ❑Website ❑Mouthguard Clinic ❑Community Event ❑Other_____

Please fill out the following information completely for accuracy with insurance, communication and Hipaa

Tell Us About You

Marital Status: ❑ Married ❑ Divorced ❑ Single ❑ Widowed

Name:_____
First M. I. Last

Preferred Name:_____ ❑ Male ❑ Female

Birthdate: _____

Cell #: _____

Alternate #: Work / Home _____

Email:_____

Preferred Contact Method: ❑ Voice message ❑ Email Can we leave a detailed message? Yes / No

Address: _____

City:_____ **State**_____ **Zip**_____

Dental Insurance policy holder? Yes No

Dental Insurance Company:_____

Employer:_____

Occupation:_____

Activities and interests :_____

Additional Information

Relation: ❑ Spouse ❑ Other_____

Name:_____

Authorization to discuss: ❑Financial Information
❑Treatment Related Information
❑Financial and Treatment Related Information

Birthdate: _____

Cell #: _____

Alternate #: Work / Home _____

Email:_____

❑ Same address

Address: _____

City:_____ **State**_____ **Zip**_____

Dental Insurance policy holder? Yes No

Dental Insurance Company:_____

Employer:_____

Occupation:_____

Person Responsible for Account

❑Self *Please fill out only if information is not listed above*

Name:_____ DOB:_____

Cell #:_____ Secondary #:_____ Can we leave a detailed message? Yes No

Address: _____ City:_____ State_____ Zip_____

Please see other side ▶

DENTAL HISTORY

Have you ever had orthodontic treatment in the past? ❑Yes ❑No
Have you been evaluated by another orthodontist recently? ❑Yes ❑No
Have x-rays been taken in the last 6 months? ❑Yes ❑No Date:_____

General Dentist:_____
Have you been seen by this dentist in the last year? ❑Yes ❑No

What is your dentist's main concern with your teeth?

_____

What is your main concern with your teeth?

_____

Have you ever had any of the following:

- *Injury to the face, mouth, teeth or chin?* ❑Yes ❑No
  If yes, please explain:_____
- *Jaw joint concerns* ❑Yes ❑No If yes, please explain:

_____

_____

- *Thumb or finger habit* ❑Yes ❑No *Habit still present?* ❑Yes ❑No
- *Speech Therapy* ❑Yes ❑No
- *Do you have sleep apnea and use a CPAP machine?* ❑Yes ❑No
- *Have you worn a night guard appliance?* ❑Yes ❑No

Do you brush your teeth daily? ❑Yes ❑No
Do you floss daily? ❑Yes ❑No

Do you smoke or use tobacco? ❑Yes ❑No
Have you been seen by a Periodontist? ❑Yes ❑No
Have you been told you have periodontal disease? ❑Yes ❑No
Has anyone in the family ever had jaw surgery? ❑Yes ❑No
Have you been informed of any missing or extra permanent teeth? ❑Yes ❑No
Is there any other dental health information you would like us to know? ❑Yes ❑No

_____

_____

MEDICAL HISTORY

Medications or supplements currently taking:

_____

_____

_____

_____

Do you need to pre-medicate before dental procedures? ❑Yes ❑No
Are your immunizations up to date? ❑Yes ❑No
Allergies to Latex/Metals/Plastics ❑Yes ❑No
Other Allergies: _____ ❑Yes ❑No
Arthritis ❑Yes ❑No
Asthma/Respiratory Condition ❑Yes ❑No
Attention Deficit Disorder/ADHD ❑Yes ❑No
Autisim ❑Yes ❑No
Birth Defects ❑Yes ❑No
Blood Disorders Anemia/Low blood sugar ❑Yes ❑No
Blood Pressure High/Low ❑Yes ❑No
Cancer/Leukemia ❑Yes ❑No
Congenital Heart Defect/Murmer ❑Yes ❑No
Cardiovascular Heart attack/Angina/Stroke ❑Yes ❑No
Diabetes. ❑Yes ❑No
Digestive System Disorders ❑Yes ❑No
Disabilities or Handicaps ❑Yes ❑No
Eating Disorder ❑Yes ❑No
Endocrine ❑Yes ❑No
Eye Conditions ❑Yes ❑No
Epilepsy ❑Yes ❑No
Hearing Impairment ❑Yes ❑No
Hearing Aids ❑Yes ❑No
Headaches/Migraines ❑Yes ❑No
Hepatitis ❑Yes ❑No
HIV +/ AIDS ❑Yes ❑No
Immune System Disorders ❑Yes ❑No
Joint Replacement ❑Yes ❑No
Kidney/Liver Problems ❑Yes ❑No
Mental Health Condition Anxiety/Depression ❑Yes ❑No
Other Condition: _____ ❑Yes ❑No
Mouthbreathing/Snoring ❑Yes ❑No
Oral Ulcers ❑Yes ❑No
Osteoporosis ❑Yes ❑No
Pregnant - Due Date:_____ ❑Yes ❑No
Seizures/Fainting ❑Yes ❑No
Sensory Conditions ❑Yes ❑No
Thyroid Condition ❑Yes ❑No
Tuberculosis (TB) ❑Yes ❑No
Tonsils/Adenoids Removed ❑Yes ❑No

Are you currently under the care of a physician for any other health information we should know about? ❑Yes ❑No

_____

_____

AUTHORIZATION AND SIGNATURE ON FILE

By Signing below:

I authorize this office and it's employees to use this form's information to act as my agent to assist with insurance reimbursement and have insurance payments made directly to this office.
I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes.

_____
Signature of patient Date

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDA and ADA

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