Welcome to Zirbel Orthodontics

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

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational.
Please fill out the following information to assist us with your child's 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_____

Tell Us About Your Child

Child's Name:_____
First M. I. Last

Preferred Name:_____ ❑ Male ❑ Female

Child's Birthdate: _____Age:_____

School:_____ Grade:_____

Activities and interests:_____

List any siblings with age:_____

Child lives with: ❑ Both Parents ❑ Mother ❑ Father ❑ Other_____

Medications or supplements currently taking:

_____

_____

Dental History

General Dentist:_____

Has your child been seen by this dentist in the last year? ❑Yes ❑No

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

_____

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

_____

Has your child been evaluated by another orthodontist? ❑Yes ❑No

Have x-rays been taken in the last 6 months? ❑Yes ❑No Date:_____

Has your child 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
  If yes, please explain:_____

Does your child brush his/her teeth daily? ❑Yes ❑No

Floss his/her teeth daily? ❑Yes ❑No

Have you been informed of any missing or extra permanent teeth? ❑Yes ❑No

Has anyone in the family ever had jaw surgery? ❑Yes ❑No

Medical History

Does your child pre-medicate before dental procedures?	❑Yes ❑No
Are 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

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

Please see other side ▶

Responsible Party Information

Please complete a section for each person sharing responsibility for your child
This request is for accuracy with insurance, communication and Hipaa

Relation: ❑ Mother ❑ Father ❑ Step Mother ❑ Step Father ❑ Guardian

Name:_____ **DOB:**_____

Cell #:_____ **Alternate #:**_____ **Email:**_____

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

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

Employer:_____ **Occupation:**_____

Is this person a dental insurance policy holder? ❑Yes ❑No **Dental Insurance Company:**_____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

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Spouse or Additional Responsible Party Name:_____ **DOB:**_____

Relation: ❑ Mother ❑ Step Mother ❑ Father ❑ Step Father ❑ Guardian

Cell #:_____ **Alternate #:**_____ **Email:**_____

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

Address: ❑ Same _____ **City:**_____ **State:**_____ **Zip:**_____

Employer:_____ **Occupation:**_____

Is this person a dental insurance policy holder? ❑Yes ❑No **Dental Insurance Company:**_____

Additional Responsible Party Information for Multiple Households

Relation: ❑ Mother ❑ Father ❑ Step Mother ❑ Step Father ❑ Guardian

Name:_____ **DOB:**_____

Cell #:_____ **Alternate #:**_____ **Email:**_____

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

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

Employer:_____ **Occupation:**_____

Is this person a dental insurance policy holder? ❑Yes ❑No **Dental Insurance Company:**_____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

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Spouse or Additional Responsible Party Name:_____ **DOB:**_____

Relation: ❑ Mother ❑ Step Mother ❑ Father ❑ Step Father ❑ Guardian

Cell #:_____ **Alternate #:**_____ **Email:**_____

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

Address: ❑ Same _____ **City:**_____ **State:**_____ **Zip:**_____

Employer:_____ **Occupation:**_____

Is this person a dental insurance policy holder? ❑Yes ❑No **Dental Insurance Company:**_____

Person Responsible for Account

❑ Both Parents ❑ Mother ❑ Father ❑ Step Mother ❑ Step Father ❑ Guardian
❑ Other_____

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 parent or guardian Date

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