F. Alfons Zaki, DDS

Welcome to Zaki Dental – Tell Us About Yourself

Name:____
Last First MI Title

Preferred Name:______________________________________ ☐ Male ☐ Female

Address:______________________________City______________State______ZIP________

SSN:__________________________________ DOB:________________________________

Home Phone:____________________________Work Phone:_______________________

Cell Phone:_____________________________E-mail Address: ____________________

Employer:______________________________Occupation: ______________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

How did you hear about our office?____

Do you prefer to be contacted for appointment confirmation via e-mail or phone? (Please circle preference)

Insurance–Primary

Subscriber Name:____________________Relationship to Patient:__________Subscriber DOB:______

Subscriber SSN/ID:______________________Subscriber Employer:____________________

Insurance CompanyName:____

Insurance Company Address:____

Insurance CompanyPhone:_________________ GroupNumber:_________________________

Insurance–Secondary

Subscriber Name:____________________Relationship to Patient:________Subscriber DOB:_______

Subscriber SSN/ID:______________________Subscriber Employer:____________________

Insurance Company Name:____

Insurance Company Address:____

Insurance Company Phone:__________________Group Number:_______________________

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Zaki Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: ____

Relationship:__________________________________ Date: __________________________

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature:____

F. Alfons Zaki, DDS

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: ____________________

Physician's Phone: ____________________

Date of last visit: ____________________

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: ____________________

Do you use tobacco in any form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants placed? ☐ Yes ☐ No

Please list each one: ____________________

Have you ever had any surgical procedures? ☐ Yes ☐ No

Please list each one: ____________________

Yes	No	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer
☐	☐	Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Facial Surgery
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Yes	No	Conditions
☐	☐	Glaucoma
☐	☐	HIV+ AIDS
☐	☐	Heart Attack
☐	☐	Heart Murmur
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	Hepatitis C
☐	☐	High Blood Pressure
☐	☐	Joint Replacement
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Sexually Transmitted Disease
☐	☐	Shingles

Yes	No	Conditions
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers

Yes	No	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Yes No **If Female, Please Answer**

☐ ☐ Are you taking Birth Control Pills?

☐ ☐ Are you pregnant?

If so, # of Weeks ________

☐ ☐ Are you nursing?

Nearest relative not living with you:

Name: ____________________ Relationship: ____________________

Address: ____________________ Phone: ____________________

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status

Signature: ____________________ Date: ____________________

F. Alfons Zaki, DDS

How may we help you today? ______________________________

Your current dental health is: ☐ Good ☐ Fair☐ Poor

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) ☐ Yes ☐ No

Are you under stress? (new job,moving,relationships) ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Is there anything you would like to change about your smile? ☐ Yes ☐ No

Are you happy with the color of your teeth? ☐ Yes ☐ No

Do your gums bleed? ☐ Yes ☐ No

How many times a do you: floss/week?______________ brush/day?______________

Are your teeth sensitive to head, cold or anything else? ☐ Yes ☐ No

Have you lost any teeth? ☐ Yes ☐ No

Have you ever had a serious/difficult problem with any previous dental work? ☐ Yes ☐ No

Have you ever had any unfavorable dental experiences? ☐ Yes ☐ No

When was your last dental cleaning? ______________________________

When was your last dental visit? ______________________________

Why did you leave your previous dentist? ______________________________

How can we accommodate you better during your dental visit?______________________________

Here at Zaki Dental we offer a wide variety of services to enhance and keep your smile beautiful. Please mark any services below you would like our friendly staff to discuss with you during your visit.

Sapphire Tooth Whitening

Veneers/Lumineers

Invisalign

Traditional Orthodontics (Brackets)

Smile Makeover

Bonding

Sealants

Crown and Bridge

Implant Crowns

Partials/Dentures

Night/Sport Guards