Dr. Paul E. Ziman
Practice Limited to Orthodontics

Eagan (Business Office)
1964 Rahncliff Court
Eagan, MN 55122

Downtown Minneapolis
531 Medical Arts Bldg.
9th Street & Nicollet Mall

Minnetonka
11004 Cedar Lake Road
Cedar Hills Shopping Ctr.

Metro Area Offices (612) 332-0130

Patient Registration & Dental/Health History

Patient Name _____ Address _____ City _____ Zip _____

Home Phone ( ) _____ Social Security # ____ - ____ - ____ Patient Birthdate ____/___/____ Email _____

Patient Occupation & Address _____ Business Phone ( ) _____

Parent/Guardian Name(s) _____ Address _____ City _____ Zip _____

Home Phone ( ) _____ Cell Phone ( ) _____ Email _____

Who is financially responsible for account? _____ Social Security # ____ - ____ - ____ Birthdate ____/___/____

Financially Responsible Occupation & Address _____ Business Phone ( ) _____

Dental Insurance _____
Claims Address _____
Group # _____
Insured Name _____
Insured SS# _____
Insured Birthdate ____/___/____
Employer _____

Second Insurance Carrier? _____
Claims Address _____
Group # _____
Insured Name _____
Insured SS# _____
Insured Birthdate ____/___/____
Employer _____

OFFICE USE ONLY **Initial Exam Completed** ____/___/____

DENTAL HISTORY (Please write in or circle the correct Yes/No answer)

1. Reason for this visit _____
2. Who referred you to our office? _____
3. Name of General Dentist _____

4. Are you having pain at this time?	Yes	No
5. Have you ever had:		
a. Orthodontic treatment? (braces)	Yes	No
b. Oral surgery?	Yes	No
c. Gum treatment?	Yes	No
d. Teeth ground or bite adjusted?	Yes	No
e. Worn bite plane or other appliance?	Yes	No
6. Have you noticed any loosening of your teeth?	Yes	No
7. Does food become caught between your teeth?	Yes	No
8. Do your gums often bleed when you brush?	Yes	No
9. Do you have any sores or lumps in or near your mouth?	Yes	No

10. Problems of the jaw. Have you ever experienced:			
a. Clicking of the jaw?	*Left/Right*	Yes	No
b. Pain (joint, ear, side of the face)?	*Left/Right*	Yes	No
c. Difficulty opening or closing?		Yes	No
d. Difficulty chewing?		Yes	No
11. Have you had any head, neck or jaw injuries?		Yes	No
12. Habits: do you?			
a. Clench or grind your teeth while awake or asleep?		Yes	No
b. Bite your lips or cheeks regularly?		Yes	No
13. Have you ever had an upsetting experience at a dental office?		Yes	No
14. Are you satisfied with the appearance of your teeth?		Yes	No
15. Has antibiotic pre-medication for dental procedures been recommended?		Yes	No
16. Is there anything else about dental treatment that might bother you?		Yes	No

If so, please explain _____

MEDICAL HISTORY (Please write in or circle the correct Yes/No answer)

1. Has there been any change in your general health within the past year?	Yes	No
2. Last physical exam was on ____/___/____		
3. Are you now under the care of a physician?	Yes	No
4. Physician's name, address & phone _____		

5. Do you or have you had any of the following diseases or problems?

1. Rheumatic fever, scarlet fever or rheumatic heart disease?	Yes	No
2. Heart defect or heart murmur?	Yes	No
3. Heart trouble, heart attack or angina?	Yes	No
4. High blood pressure?	Yes	No
5. Stroke?	Yes	No
6. Pacemaker?	Yes	No
7. Heart Surgery?	Yes	No

MEDICAL HISTORY (continued)

8. Glaucoma?	Yes	No
9. Metal allergy?	Yes	No
10. Hepatitis?	Yes	No
11. Other allergies?	Yes	No
12. Sinus trouble?	Yes	No
13. Lung or breathing problems?	Yes	No
14. Asthma or hay fever?	Yes	No
15. Hives or skin rash?	Yes	No
16. Fainting spells or seizures?	Yes	No
17. Diabetes?	Yes	No
18. Liver disease or jaundice?	Yes	No
19. Thyroid problems?	Yes	No
20. Arthritis?	Yes	No
21. Hip replacement or implant?	Yes	No
22. Stomach ulcers?	Yes	No
23. Kidney trouble, transplant or dialysis?	Yes	No
24. Tuberculosis?	Yes	No
25. Low blood pressure?	Yes	No
26. Chemical dependency?	Yes	No
27. Venereal disease?	Yes	No
28. Pain in chest upon exertion?	Yes	No
29. Shortness of breath after exercise?	Yes	No
30. Swelling of the ankles?	Yes	No
31. Shortness of breath while lying down or do you need extra pillows when you sleep?	Yes	No
32. Persistent cough or cough up blood?	Yes	No
6. Have you had abnormal bleeding associated with previous tooth extractions, surgery or injuries?	Yes	No
7. Do you have any blood disorder such as leukemia or anemia?	Yes	No
8. Have you had surgery or x-ray treatment for a tumor, growth or any other condition of your lips or mouth?	Yes	No

9. Are you taking any of the following?		
a. Antibiotics or sulfa drugs	Yes	No
b. Anticoagulants (blood thinners)	Yes	No
c. Medication for high blood pressure	Yes	No
d. Cortisone (steroids)	Yes	No
e. Tranquilizers	Yes	No
f. Dilantin	Yes	No
g. Antihistamines	Yes	No
h. Aspirin	Yes	No
i. Insulin, tolbutaminde (Orinase) or any other drugs to control blood sugar	Yes	No
j. Digitalis or drugs for heart trouble	Yes	No
k. Nitroglycerin	Yes	No
l. Oral contraceptives	Yes	No
m. Other? _____	Yes	No
10. Are you allergic to or have you had reactions to?		
a. Local anesthetics like novocaine	Yes	No
b. Penicilliin or other antibiotics	Yes	No
c. Sulfa drugs	Yes	No
d. Barbituates, sedatives or sleeping pills	Yes	No
e. aspirin	Yes	No
f. Iodine	Yes	No
g. Other? _____	Yes	No
11. Have you had any serious trouble associated with a previous dental treatment?	Yes	No
12. Does anyone in your family have disabilities, birth defects or growth related problems?	Yes	No
13. Do you wear contact lenses?	Yes	No
14. Women:		
a. Are you pregnant or think you may be pregnant?	Yes	No
b. Are you nursing?	Yes	No
15. Do you have any condition, disease or problem not listed that you think we should know about?	Yes	No
16. Are you at risk for acquiring HIV or have you been diagnosed as a carrier?	Yes	No

Signature _____ **Date** _____

(Patient or Parent/Guardian if Patient is under 18 years)

PERMISSION & RELEASE FORM

This portion must be signed for diagnostic records to be obtained in our office.

I hereby give my permission to Dr. Paul E. Ziman and/or his staff to obtain diagnostic records in the way of radiographs (x-rays), plaster models, photographs, or other diagnostic records as necessary in the determination of treatment to be rendered. I further agree to authorize the release of these records and/or duplicates to my insurance carrier should they be requested. I understand that there may be a charge for duplication should my insurance carrier so request. Should I decide not to continue with the proposed treatment, I understand that there will be a charge for the records and consultation already completed. Fees for these services may be submitted to my insurance company for payment. Charges for these services are included as part of the overall treatment should I elect to accept the proposed treatment plan.

Signature _____ **Date** _____

(Patient or Parent/Guardian if Patient is under 18 years)

Signature _____ **Date** _____

(Witness)

_____ **By initialing, I acknowledge that I have been provided a copy of Dr. Paul E. Ziman's Notice of Privacy Practices outlining office procedures with regard to the privacy and exchange of my private health information.**