## 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** 

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DENTAL HISTORY (Please write in or circl	le the correct Ye	s/No answer)	10. Problems of the jaw. Have you ever experienced:	Voc	No
			a. Clicking of the jaw? Left/Right	Yes Yes	No No
1. Reason for this visit			a. Clicking of the jaw? Left/Right b. Pain (joint, ear, side of the face)? Left/Right	Yes Yes Yes	No No No
Reason for this visit     Who referred you to our office?			a. Clicking of the jaw?  b. Pain (joint, ear, side of the face)?  c. Difficulty opening or closing?  d. Difficulty chewing?	Yes	No
Reason for this visit     Who referred you to our office?			a. Clicking of the jaw? b. Pain (joint, ear, side of the face)? c. Difficulty opening or closing? d. Difficulty chewing?  11. Have you had any head, neck or jaw injuries?	Yes Yes	No No
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?			a. Clicking of the jaw? b. Pain (joint, ear, side of the face)? c. Difficulty opening or closing? d. Difficulty chewing?  11. Have you had any head, neck or jaw injuries? 12. Habits: do you?	Yes Yes Yes	No No No
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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? 5. Have you ever had: a. Orthodontic treatment? (braces) b. Oral surgery?	Yes Yes Yes	No No No	a. Clicking of the jaw?  b. Pain (joint, ear, side of the face)?  c. Difficulty opening or closing?  d. Difficulty chewing?  11. Have you had any head, neck or jaw injuries?  12. Habits: do you?  a. Clench or grind your teeth while awake or asleep?  b. Bite your lips or cheeks regularly?	Yes Yes Yes Yes	No No No No
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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? 5. Have you ever had:	Yes	No N	a. Clicking of the jaw?  b. Pain (joint, ear, side of the face)?  c. Difficulty opening or closing?  d. Difficulty chewing?  11. Have you had any head, neck or jaw injuries?  12. Habits: do you?  a. Clench or grind your teeth while awake or asleep?  b. Bite your lips or cheeks regularly?  13. Have you ever had an upsetting experience at a dental office?  14. Are you satisfied with the appearance of your teeth?  15. Has antibiotic pre-medication for dental procedures been recommended?  16. Is there anything else about dental treatment that might bother you?  If so, please explain  5. Do you or have you had any of the following diseases or problems?  1. Rheumatic fever, scarlet fever or rheumatic heart disease?  2. Heart defect or heart murmur?  3. Heart trouble, heart attack or angina?	Yes	No No No No No

8. Claucoma?  9. Metal allery?  Yes No  0. Addication for high blood pressure  Yes No  10. Hapstifist?  Yes No  11. Other allergy?  Yes No  12. Large of breathing problems?  Yes No  13. Large of breathing problems?  Yes No  14. Asthma or law fower?  Yes No  15. Hives or skin easil?  Yes No  16. Fainting spells or seizures?  Yes No  17. Dubeters?  Yes No  18. Liver disease or jaundice?  Yes No  18. Liver disease or jaundice?  Yes No  19. Thipstofering for the strength problems?  Yes No  19. Thipstofering problems?  Yes No  10. Are you allege to or have you lad reactions for yes No  22. Stromach theres?  23. Stromach deems?  Yes No  10. Are you allege to or have you lad reactions for yes No  24. Habercularis?  Yes No  25. Low blood pressure?  Yes No  16. Braining applies or ediplying or yes No  17. Do you have any blood disorder such as believe the automatic of your lips or mouth?  Yes No  28. Persuancial expendency?  Yes No  19. Stromach alleres?  Yes No  29. Shormess of hearth five plant or dialypisis?  Yes No  20. Swelling of the anales?  Yes No  21. Hip replacement or implant?  Yes No  22. How blood pressure?  Yes No  23. How blood pressure?  Yes No  24. Haberculosis?  Yes No  25. Low blood pressure?  Yes No  26. Ghenrical dependency?  Yes No  27. Venereal disease?  Yes No  28. Persuancial or cought up blood?  Yes No  19. Do you have any blood disorder such as leukemen of or such have you had approved in the third you may be grey?  Yes No  19. Do you have any phood disorder such as leukemen or cought up blood?  Yes No  10. Are you alleging of the anales?  Yes No  11. Here you had any serious troub associated with previous though the category Pes No  28. Persuancial cought or cought up blood?  Yes No  19. Do you have any blood disorder such as leukemen or analy have diabilities?  Yes No  10. Are you alleging of the anales?  Yes No  10. Are you alleging of the anales?  Yes No  10. Do you were contacted in our office.  PERMISSION & RELEASE FORM  This portion must be signed for diagnostic records as necessary in	MEDICAL HISTORY (continued)			9. Are you taking any of the following?		
9. Metal allergy? 10. Hepsthiris? 10. Other allergies? 11. Other allergies? 12. Sinat rounbe? 12. Sinat rounbe? 13. Lange or beathing problems? 14. Singe or beathing problems? 15. Hives or skin rash? 15. Hives or skin rash? 16. Fainting spells or sezuruse? 17. Pollactes? 18. Liver disease or jaundice? 19. No 19. Thickets? 19. No 10. Digitalis or drugs for learn frought or the problems? 19. Thickets? 19. T			* 1			
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11. Other allengine? 12. Stoms trouble? 13. Lung or breathing problems? 14. Asthman or hay feve? 15. Bives or skin and? 16. Fairbid spalls or settures? 16. Fairbid spalls or settures? 17. Ves. No. 18. Liver disease or jumilate? 19. The problems? 19. The problems? 19. Styrold problems.						
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22. Stomach ulces? 23. Kidney trouble, transplant or dialysis? 24. Tuberculosis? 25. Low blood pressure? 25. Low blood pressure? 26. Chemical dependency? 27. Veneral disease? 28. Pain in clost upon exertion? 29. Shartness of breath after exercise? 30. Swelling of the ankles? 31. Shortness of breath after exercise? 30. Swelling of the ankles? 31. Shortness of breath after exercise? 32. Perisitent cough or cough up blood? 33. Swelling of the ankles? 34. Pain in clost upon exertion? 35. Have you had almost an emaily have disabilities, birth defects or growth related problems? 36. Have you had almormal obeding associated with previous dental treatment? 37. Do you have any blood disorder such as leave you had almormal obeding associated with previous tooth extractions, surgery or injuried? 36. Have you had almormal obeding associated with previous tooth extractions, surgery or injuried? 37. Do you have any blood disorder such as leave you had almormal obeding associated with previous tooth extractions, surgery or injuried? 38. Have you had surgery or x-ray treatment for a tumor, growth or any other condition of your lips or mouth? 39. Shave you had surgery or x-ray treatment for a tumor, growth or any other condition of your lips or mouth? 39. This portion must be signed for diagnostic records to be obtained in our office.  30. In the provious tooth of the condition of your lips or mouth? 30. This portion must be signed for diagnostic records as necessary in the determination of tree ment to be rendered. I further agree to authorize the release of these records and of outplicates to my insurance carrier should they be requested. I understand that there may be a charge for duplication should my insurance carrier should they be requested. I understand that there may be a charge for duplication should my insurance carrier should they be requested. I understand that there may be a charge for duplication should my insurance carrier should they be requested. I understand that there may be a charge for duplication should l					res	INO
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26. Chemical dependency? Yes No						
27. Venered diseases?  28. Pain in chest upon exertion?  29. Shortness of breath after exercise?  29. Shortness of breath after exercise?  29. Shortness of breath after exercise?  30. Swelling of the ankles?  29. Shortness of breath while lying down or all the proposed centary pillows of the centary pillows						
28. Pain in chest upon exertion? Yes No 29. Shortness of breath which after exercise? Yes No 30. Swelling of the ankles? 31. Shortness of breath while lying down or do you need extra pillows when you sleep? 31. Shortness of breath while lying down or do you need extra pillows 31. Shortness of breath while lying down or do you need extra pillows 32. Persistent cough or cough up blood? Yes No 33. Persistent cough or cough up blood? Yes No 34. Women: 35. Have you had abnormal bleeding associated with previous tooth extractions, surgery or injuries? 4. Do you have any blood disorder such as leakemin or anemia? Yes No 5. Have you had surgery or x-ray treatment for a tumor, growth or any other condition of your lips or mouth? 4. Women: 4. Are you purganant or think you may be pregnant or think you may be pregnant? 5. Have you had surgery or x-ray treatment for a tumor, growth or any other condition of your lips or mouth? 5. Have you had surgery or x-ray treatment for a tumor, growth or any other condition of your lips or mouth? 5. Have you have any plood disorder such as leakemin or anemia? 6. Have you have any condition, disease or problem not listed that you think we should know about? 6. Are you at risk for acquiring HIV or have you been diagnosed as a carrier? 6. Are you at risk for acquiring HIV or have you been diagnosed as a carrier? 7. No 7. Do you have any other diagnostic records to be obtained in our office. 8. Hereby give my permission to Dr. Paul E. Ziman and/or his staff to obtain diagnostic records in the way of radigraphs (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 carriers should they be requested. I understand that there may be a charge for duplication should my insurance carriers on the decident of the overall treatment should I elect to accept the proposed treatment plan.  6. Have you have any event distinct provided and p						
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32. Persistent cough or cough up blood? Yes No 13. Do you wear contact lenses? Yes No 32. Persistent cough or cough up blood? Yes No 14. Women: a. Are you pregnant? Yes No 15. Do you have any condition, disease or problem not listed that you think we should know about? 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 16. Are you at risk for acquiring HIV or have you been diagnosed as a carrier? Yes No 16. Are you at risk for acquiring HIV or have you been diagnosed as a carrier? Yes No 16. Are you at risk for acquiring HIV or have you been diagnosed as a carrier? Yes No No 16. Are you at risk for acquiring HIV or have you been diagnosed as a carrier? Yes No No 16. Are you at risk for acquiring HIV or have you been diagnosed as a carrier? Yes No No 16. Are you at risk for acquiring HIV or have you been diagnosed as a carrier? Yes No No 16. Are you at risk for acquiring HIV or have you been diagnosed as a carrier? Yes No No No 16. Are you at risk for acquiring HIV or have you been diagnosed as a carrier? Yes No No No 16. Are you at risk for acquiring HIV or have you been diagnosed as a carrier? Yes No No No 16. Are you at risk for acquiring HIV or have you been diagnosed as a carrier? Yes No				birth defects or growth related problems?	Yes	No
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a. Are you pregnant or think you may be with previous tooth extractions, surgery or injuries? 7. Do you have any blood disorder such as leukemia or anemia? 8. Have you had surgery or x-ray treatment for a tunnor, growth or any other condition of your lips or mouth?  Yes No  15. Do you have any condition, disease or problem leukemia or anemia? 9. Yes No  16. Are you at risk for acquiring HIV or have you been diagnosed as a carrier?  No  Signature  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 radigraphs (x-rays), plaster models, photographs, or other diagnostic records as necessary in the determination of treament 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 should they be requested. I understand that there may be a charge for duplication should my insurance carrier 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 compar for payment. Charges for these services are included as part of the overall treatment should I elect to accept the proposed treatment plan.  Signature  (Patient or Parent/Guardian if Patient is under 18 years)  Signature  (Patient or Parent/Guardian if Patient is under 18 years)						
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