

# Dr. Paul E. Ziman

## Practice Limited to Orthodontics

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

Northfield  
200 Division Street  
Corner of 2nd & Division

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

Northfield (507) 663-1669

### 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 _____	Second Insurance Carrier? _____
Claims Address _____	Claims Address _____
Group # _____	Group # _____
Insured Name _____	Insured Name _____
Insured SS# _____	Insured SS# _____
Insured Birthdate ____/____/____	Insured Birthdate ____/____/____
Employer _____	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<br>do you need extra pillows<br>when you sleep?                        | Yes | No |
| 32. Persistent cough or cough up blood?  | Yes | No |
| 6. Have you had abnormal bleeding associated<br>with previous tooth extractions, surgery<br>or injuries?           | Yes | No |
| 7. Do you have any blood disorder such as<br>leukemia or anemia?   | Yes | No |
| 8. Have you had surgery or x-ray treatment for a<br>tumor, growth or any other condition<br>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, tolbutamide (Orinase) or any other<br>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. Penicillin 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 \_\_\_\_\_

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

Date \_\_\_\_\_

**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 \_\_\_\_\_

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

Date \_\_\_\_\_

Signature \_\_\_\_\_

(Witness)

Date \_\_\_\_\_

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.