Welcome to our office!

We look forward to getting to know you!

ZODY orthodontics

Roger Zody, DDS, MS
3300 Riverside Drive, Suite 150
Columbus, OH 43221
T 614.451.0651 F 614.451.6151

About You

Today's Date _____

Name: _____
Last First MI

Nickname/Preferred Name:

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Birthdate: ___/___/___ Age: _____

☐ Male ☐ Female

SSN#: _____

Driver's License #: _____

Hm #: (___) _____ Wk #: (___) _____ Ext: _____

Cell #: (___) _____

Email: _____

Best ways to reach you:

☐ Home ☐ Cell ☐ Work ☐ Email

Best times to reach you: _____

Home Residence Information

Home Address: _____

_____
City State Zip

How long at this residence? _____

☐ Single ☐ Married ☐ Partnered
☐ Divorced ☐ Separated ☐ Widowed

Who may we thank for referring you to our office:

_____

General Dentist: _____

Last Visit Date: _____

Employer Information

Employer: _____

Employer's Address: _____

_____
City State Zip

How many years with Employer? _____

Occupation: _____

Person responsible for Account: ☐ Self ☐ Other

Billing Address: _____

_____
City State Zip

Hm #: (___) _____ Cell #: (___) _____

Wk #: (___) _____ Ext: _____ Birthdate: ___/___/___

SSN#: _____

DL#: _____

Partner/Spouse Information

Name: _____

Cell #: (___) _____

Wk #: (___) _____ Ext: _____

Birthdate: _____ SSN#: _____

DL#: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

Primary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (___) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Policy Owner's Birthdate: ___/___/___ SSN#/ID#: _____

Policy Owner's Employer: _____

Employer's Address: _____

_____
City State Zip

Relationship to Patient: _____

Secondary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (___) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Policy Owner's Birthdate: ___/___/___ SSN#/ID#: _____

Policy Owner's Employer: _____

Employer's Address: _____

_____
City State Zip

Relationship to Patient: _____

Friend/Relative not living with you

Name: _____ Relation: _____

Hm #: (___) _____ Wk #: (___) _____ Ext: _____

Payment of Services

Payment is due in full at time of treatment unless prior arrangements have been approved. If this office accepts my insurance, I understand that I am responsible for payment of service rendered and also responsible for paying any co-payments and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company. This office reserves the right to verify credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office use the services of one or more credit reporting services.

_____ _____
Signature Date

Continue to other side →

About Your Health

How would you describe your health? Good Fair Poor

Physician:_____ Phone #:(____)_____ Date of Last Visit:_____

Are you currently being treated by a physician? Yes No Reason: _____

_____

Please list all drugs/medications you are currently taking (including over the counter): _____

_____

For Women: Are you pregnant? Yes No Week #:_____ Are you nursing? Yes No

Are you taking birth control medication? Yes No Medication: _____

Do you have any allergies to foods and/or drugs/medications? Yes No

Please list: _____

Allergy to (please circle): Latex Yes No Metals/Nickel Yes No Plastics Yes No

Please tell us if you have had any of the following (past and present)? (Please circle)

Y	N	Abnormal Bleeding	Y	N	ADD/ADHD	Y N	Alcohol/Drug Abuse
Y	N	Allergies to any Drugs	Y	N	Allergy to Latex/Metals	Y N	Allergy to Plastic
Y	N	Anemia	Y	N	Arthritis	Y N	Asthma
Y	N	Bisphosphonate Therapy	Y	N	Convulsions/Epilepsy	Y N	Birth Defects/Hereditary Problems
Y	N	Cancer/Chemotherapy	Y	N	Chest Pain/ Angina	Y N	Emphysema
Y	N	Fainting Spells	Y	N	Frequent Headaches	Y N	Glaucoma
Y	N	Heart Attack/Surgery	Y	N	Herpes/Fever Blisters	Y N	High Blood Pressure
Y	N	Kidney Problems	Y	N	Liver Problems	Y N	Low Blood Pressure
Y	N	Mitral Valve Prolapse	Y	N	Pacemaker	Y N	Psychiatric Problems
Y	N	Shingles	Y	N	Sinus Problems	Y N	Sickle Cell Disease/Traits
Y	N	Stroke	Y	N	Ulcers	Y N	Venereal Disease
Y	N	Congenital Heart Defect	Y	N	Diabetes	Y N	Handicaps/Disabilities
Y	N	Hearing Impairment	Y	N	Depression/Anxiety	Y N	Heart Murmur
Y	N	Any Hospital Stays	Y	N	Hemophilia	Y N	Any Operations
Y	N	Hepatitis	Y	N	HIV+/AIDS	Y N	Artificial Bones/Joints/Valves
Y	N	Lupus	Y	N	Tuberculosis	Y N	Rheumatic/Scarlet Fever
Y	N	Delayed Growth	Y	N	Radiation Therapy	Y N	Difficulty Breathing
Y	N	Colitis	Y	N	Other(Please explain below)		

Please explain any "Y/Yes" answers:_____

_____

Orthodontic/Dental Concerns

Have you been evaluated or had orthodontic treatment before? Y N

Please explain your reason/concern for an orthodontic evaluation: _____

Do you have or have you had any of the following:

Injuries to the face, mouth, teeth or chin? Y N

Pain/discomfort in your jaw joint (TMJ/TMD)? Y N

Speech problem? Y N

Problem or concern associated with previous dental work? Y N

Missing or extra permanent teeth? Y N

Do you still have wisdom teeth? Y N

What is your current dental health? ☐Good ☐Fair ☐Poor

Are you happy with the way your smile looks or the way your teeth look? Y N What would you change?_____

_____

Do you wish to address/discuss any issues privately (in the absence of people accompanying you today)? Y N

Sign Here

I have read and understand that the information that I have given is correct to the best of my knowledge. It is my responsibility to inform this office of any changes in my medical health status. I will not hold my orthodontist or any member of the office staff responsible for any errors or omissions that I have made in completion of this form. I authorize the office staff to perform the necessary dental services I may need.

_____

Signature Date

Office Use Only

Doctor Review Signature: _____ Date: _____

Doctor Comments: _____

_____

_____