Welcome to Omana Orthodontics

Patient Information

Patient Name:_____ Date:_____

Preferred Name:_____ Birthdate:_____ Age:_____

Mailing Address: _____ City:_____ ST:_____ Zip:_____

Home #: (___)_____ Cell #: (___)_____ Email:_____

Dentist:_____ Last Visit:_____ Employer:_____

Who referred you to our office:_____ Dentist__ Friend__ Insurance__ Phonebook__ other__

Family Information

Spouse or Parent's information

Name:_____ Birthdate:_____ Home#:_____ Cell#:_____

Mailing Address:_____ City:_____ ST:_____ Zip:_____

Email:_____ Marital Status:_____ SSN:_____

Employer:_____ Occupation:_____ Years employed:_____

Name of nearest Friend or Relative not living with you:_____ Phone #:_____

Financially Responsible

Name:_____ Relation:_____

Home #:_____ Work #:_____ Cell#:_____ Email:_____

Address:_____ Own or Rent

Previous Address (if less than 3 yrs) _____

Primary Insurance Company:_____ Policy Holder:_____

Insurance Company Address:_____ Phone #: _____

Policy ID (or SSN):_____ Group #:_____Policy Holder Birthdate:_____

Employer_____ Orthodontic Benefit:_____

Secondary Insurance Company:_____ Policy Holder:_____

Insurance Company Address:_____ Phone #: _____

Policy ID (or SSN):_____ Group #:_____Policy Holder Birthdate:_____

Employer_____ Orthodontic Benefit:_____

Please complete the dental and medical history on the back of this page. Thank you!!

Dental and Orthodontic History

In your words, what is the orthodontic problem? _____

Have any other family member(s) had orthodontic treatment? _____

Have you had any previous orthodontic treatment or consultation? Yes No

If so, what was completed and by whom? _____

Has anyone in the family had: A similar condition: _____

A similar facial appearance: _____

What do you consider to be the main benefits of orthodontic correction:

Cosmetic ____ Functional ____ Psychological/ Emotional ____ Other ____

Explain:_____

Please circle if any are applicable now or in the past

Teeth that are shifting	Jaw locks	Clenching of teeth
Previous thumb sucking	Presently thumb sucking	Fluoride treatments
Injury involving teeth	Injury involving jaw	Speech Therapy
Jaw/joint sounds	Frequent canker sores	jaw/joint pain
Wake up with sore jaw	Wake up with sore teeth	Facial pain
Jaw "tires" at mealtime	Discomfort from gums	Grinding teeth
Discomfort from teeth	Neck or shoulder pain	Frequent headaches
Apprehensive about dental care		

Explain_____

_____

Medical History

Please circle if any are applicable now or in the past

Ever been hospitalized	Taking Medication	Heart murmur
Allergic to medication	Snore when sleeping	Asthma
Other allergies	Adenoids removed	Emotional problems
Sounds "stuffy"	Frequent sore throats	Prolonged bleeding
Abnormal growth	Tonsils removed	Hepatitis
Diabetes	Rheumatic Fever	Arthritis
Heart Disease	Hormone therapy	Epilepsy
Transmissible disease	AIDS/HIV	Pregnant
Started menstruation (girls)		

Explain_____

_____

Are you under the care of a physician for a specific condition not listed above?_____

If yes, please describe_____

I understand that the information that i have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status and/or insurance information. I authorize the dental staff to perform the necessary orthodontic services I need.

Signature _____ Date _____

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending financing for treatment fees.

Signature _____ Date _____