Welcome to Omana Orthodontics

Patient Information

Patient Name:______________________________ Date:____________

Preferred Name:____________________ Birthdate:______________ Age:_________

Mailing Address: ____________________ City:_____________ ST:_____ Zip:________

Home #: (____)____________ Cell #: (____)____________ Email:____________________

Dentist:______________ Last Visit:____________ School:______________ Grade:_____

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

Favorite Sports or Hobbies:______________________________

Siblings: ______________________________

Family Information

Father's information

Name:______________ Birthdate:________ Home#:__________ Cell#:__________

Mailing Address:____________________ City:__________ ST:______ Zip:________

Email:______________________ Marital Status:__________ SSN:_________

Employer:________________ Occupation:____________ Years employed:________

Mother'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:__________

We will bill your insurance, and if necessary, re-bill when an error has been made. However, it is not our responsibility to make sure that your insurance company makes the payment. It is the responsibility of the insured. We will give your insurance company 60 days to make payment.

We will make every effort possible to assist you in making your claim. If you are disputing a non payment, this is between you and your insurance carrier. We cannot carry a balance while you are disputing a claim.

Dental and Orthodontic History

In your words, what is the orthodontic problem? ____________________

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

What is the patients attitude towards orthodontic treatment? ____________________

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

If so, what was completed and by whom? ____________________

Is the Patient adopted? Yes No

If so, does the patient know? __________

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

A similar facial appearance: ____________________

A history of early or late pubertal changes: ____________________

Explain:____________________

Does the patient brush his/her teeth daily? __________ How many times? __________

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____________________

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Medical History

Please circle if any are applicable now or in the past

Ever been hospitalized	Taking Medication	Heart murmur
Allergic to medication	Snores 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____________________

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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 child's medical status and/or insurance information. I authorize the dental staff to perform the necessary orthodontic services my child needs.

Signature of Parent or Guardian ____________________ 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 of Parent or Guardian ____________________ Date __________