

# H.M. Omana D.D.S., M.S

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## Patient Information

Date: \_\_\_\_\_  
Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Age: \_\_\_\_\_ M/F  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Cell: \_\_\_\_\_

General Dentist: \_\_\_\_\_ Last visit date: \_\_\_\_\_  
Whom may we thank for referring you to our office? \_\_\_\_\_

## Family Information

### Spouse / Parent / Guardian Information

Name: _____	Name: _____
Address: _____	Address: _____
Phone #'s: Home _____ Cell _____	Phone #'s: Home _____ Cell _____
Work _____	Work _____
Employer: _____	Employer: _____
Job Title: _____	Job Title: _____

## Person Responsible for Account

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

## Insurance Information

Name of PRIMARY Insurance: _____	Name of SECONDARY insurance: _____
Insurance Address _____	Insurance Address _____
Insurance Phone # _____	Insurance Phone # _____
Policy Holder _____	Policy Holder _____
Policy Holder's Date of Birth _____	Policy Holder's Date of Birth _____
Social Security or ID # _____	Social Security or ID # _____
Name of Employer _____	Name of Employer _____
Group # _____	Group # _____

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 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 pending claim.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Over

What is the main problem as you see it? \_\_\_\_\_

Has anyone in the family had braces? \_\_\_\_\_

How do you feel about wearing braces? \_\_\_\_\_

Have you ever been evaluated or had orthodontic treatment before? \_\_\_\_\_

Explain \_\_\_\_\_

Has anyone in the family had: A similar condition \_\_\_\_\_

A similar facial appearance \_\_\_\_\_

Explain \_\_\_\_\_

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

\_\_\_Cosmetic      \_\_\_Functional      \_\_\_Psychological/Emotional

Other: \_\_\_\_\_

**Medical History**

Please circle if any are applicable now or in the past

Ever been hospitalized  
Allergic to medication  
Other allergies  
Sounds "Stuffy"  
Abnormal growth  
Diabetes  
Heart disease  
Transmissible disease  
Started menstruation

Taking medication  
Snoring when sleeping  
Adenoids removed  
Frequent sore throats  
Tonsils removed  
Rheumatic fever  
Hormone therapy  
AIDS/ HIV

Heart murmur  
Asthma  
Emotional problems  
Prolonged bleeding  
Hepatitis  
Arthritis  
Epilepsy  
Pregnant

Explain: \_\_\_\_\_

Please circle if any are applicable now or in the past

Teeth that are shifting  
Previous thumb sucking  
Injury involving teeth  
Jaw/joint sounds  
Wake up with sore jaw  
Jaw "tires" at mealtime  
Discomfort from teeth  
Apprehensive about dental care

Jaw locks  
Presently thumb sucking  
Injury involving jaw  
Frequent canker sores  
Wake up sore teeth  
Discomfort from gums  
Neck or shoulder pain

Clenching of teeth  
Fluoride treatments  
Speech therapy  
Jaw/ joint pain  
Facial pain previous  
Grinding teeth  
Frequent headaches

Explain: \_\_\_\_\_

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.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Agreement for Extension of Credit**

In accordance with the federal Truth-In-Lending Act, please be advised of the following office policy in connection with the extension of credit. By signing of this agreement, the responsible party agrees to authorize a credit report to be obtained if necessary.

X \_\_\_\_\_ Date: \_\_\_\_\_

\*This office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA.