

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

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Patient Information

Date: _____
Name: _____ Preferred Name: _____ M/F
D.O.B. _____ Age: _____ Grade: _____ School Attending: _____
Hobbies: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone #: _____ Cell: _____

Who is accompanying the patient today? _____ Relation: _____
List brothers/ sisters with age: _____
General Dentist: _____ Last visit date: _____
Whom may we thank for referring you to our office? _____

Family Information

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 does the patient feel about wearing braces? _____

Has the patient ever been evaluated or had orthodontic treatment before? _____

Explain _____

Is the patient adopted? _____

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? _____

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

Snores 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 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: _____

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.