Welcome to Ohmart Orthodontics «PatientFirstName»!

Patient's Name «PatientFirstName» «PatientLastName»	**M / F**	**Date of Birth** «PatientBirthday»	**Age**
Patient's Address (Street #, P.O. Box) «PatientAddress1»		**City, State** and **Zip Code** «PatientCityStZip»	

Home □_____Cell□_____Email_____
Please check primary phone number (for appointment reminder)

Emergency contact_____ Cell_____Relation to patient_____

Patient's Dentist_____Office Phone Number_____

Who may we thank for referring you to us? (check one)
□ Patient's Dentist □ Location □ Insurance □ Patient_____
□ Other (please explain)_____

Have any other family members been seen here at Ohmart Orthodontics?_____
Have you received previous orthodontic treatment?_____
What do you want to achieve from orthodontics?_____
Do you have any medical conditions/concerns that we may need to know about? NO / YES (if YES please explain)
_____
Medications that you take regularly?_____

_____*Financially Responsible **YES / NO**
(relation to patient: *SELF, SPOUSE, MOTHER, FATHER, GUARDIAN, STEPPARENT, GRANDPARENT, ETC.)*

Name		
Phone		
Email		
S.S.#	DOB	
Occupation		
Business Name		
Business Phone		

_____*Financially Responsible **YES / NO**
(relation to patient: *SELF, SPOUSE, MOTHER, FATHER, GUARDIAN, STEPPARENT, GRANDPARENT, ETC.)*

Name		
Phone		
Email		
S.S.#	DOB	
Occupation		
Business Name		
Business Phone		

*Alternate address, if different from patient: (this includes the billing address for the insurance holder, if different from patient)
Name _____Relation patient_____
Address_____
(Street #, P.O. Box) (City, State) (Zip Code)

DENTAL INSURANCE INFORMATION *Is patient covered by dental insurance? □ yes □ no

Primary
Insurance company_____ Phone #_____
Subscriber Name_____ Subscriber DOB_____
Subscriber ID#_____ Group #_____ Relation to Patient_____
Claims address:_____

Secondary
Insurance company_____ Phone #_____
Subscriber Name_____ Subscriber DOB_____
Subscriber ID#_____ Group #_____ Relation to Patient_____
Claims address:_____

I have read the "Notice of Privacy Practices" and declare that I have disclosed all insurance information in its entirety.

*Signature:*_____*Date:*_____