# Welcome to Ohmart Orthodontics!

| **Patient's Name** | **M / F** | **Date of Birth** |
|---|---|---|
| **Patient's Address** (Street #, P.O. Box) | **City, State** and **Zip Code** | |

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

Who does patient live with? (check one)
□ Both Parents □ Mother □ Father □ Mother & Stepparent □ Father & Stepparent
□ Other (please explain)_____

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?_____
Has the patient received previous orthodontic treatment?_____
Does the patient have any health problems or special needs?_____
Medications that the patient takes regularly?_____

| (relation to patient: *SELF, MOTHER, FATHER, GUARDIAN, STEPPARENT, GRANDPARENT, ETC.)* | | (relation to patient: *SELF, MOTHER, FATHER, GUARDIAN, STEPPARENT, GRANDPARENT, ETC.)* | |
|---|---|---|---|
| Name | | Name | |
| Phone | | Phone | |
| Email | | Email | |
| S.S.# | DOB | S.S.# | DOB |
| Occupation | | Occupation | |
| Business Name | | Business Name | |
| Business Phone | | Business Phone | |

Alternate address, if different from patient: □ Mother □ Father □Other_____
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:*_____