## New patient packet · Omerza Orthodontics

Three forms, about ten minutes with a pen: who the patient is, the medical and dental history, and the consents. Print them, fill them in, and bring them to the first visit; the visit then starts in the chair instead of on a clipboard. Or arrive ten minutes early and we hand you the same pages.

**Please also bring:**

- the dental insurance card, if there is one
- a list of medications
- recent X-rays from the dentist, or the name of the practice so we can ask

Please do not email completed forms; they hold health information. Questions: Canton (330) 492-7920.

# Omerza Orthodontics

**Canton** 4412 Whipple Ave NW, Canton, OH 44718 · (330) 492-7920

## New patient information

Please print clearly · Today's date _____

### PATIENT

Last name | First name | Middle | Goes by

Date of birth | Age | School or employer | Grade

Street address | City | State | ZIP

Patient's cell (if any) | Patient's email (if any) | OK to text the patient? ☐ Yes ☐ No

Family dentist | Dentist's phone | Last cleaning (month/year)

How did you hear about us? (dentist, friend or family, Google, Facebook, school, our sign) | Whom may we thank?

### RESPONSIBLE PARTY the adult responsible for the account (skip if that is the patient)

Last name | First name | Relationship to patient | Date of birth

Address, if different from the patient's | City, state, ZIP

Cell | Work or other phone | Email

Employer | Occupation | Reach you by: ☐ Call ☐ Text ☐ Email

### SECOND PARENT OR GUARDIAN if any

Name | Relationship | Cell | Email | Lives with patient? ☐ Yes ☐ No

### EMERGENCY CONTACT someone not living with the patient

Name | Relationship | Phone

### DENTAL INSURANCE bring the card; we check the orthodontic benefit for you

Does the patient have dental insurance? ☐ Yes ☐ No ☐ Not sure  Does it include orthodontic coverage? ☐ Yes ☐ No ☐ Not sure

**Primary plan**

Subscriber's name (whose plan it is) | Subscriber's date of birth | Relationship to patient

Insurance company | Member ID | Group number | Subscriber's employer

**Second plan**, if the patient is covered twice

Subscriber's name | Subscriber's date of birth | Insurance company | Member ID | Group number

We use this information to care for the patient, to reach you, and to file insurance claims on your behalf. It is kept as described in our Notice of Privacy Practices. Please tell us when anything on this page changes.

Signature of patient, or parent or guardian if the patient is under 18 | Date

# Omerza Orthodontics

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## Medical & dental history

Answer for the patient · Today's date _____

Patient's name | Date of birth | Filled in by (if not the patient)

## MEDICAL

Physician or pediatrician | Physician's phone | Last physical (month/year) | In good health? ☐ Yes ☐ No

Now under a doctor's care for | Hospital stays or operations (what, when)

Has the patient ever had, or do they now have:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Heart condition or murmur | ☐ Y ☐ N | Artificial heart valve or joint | ☐ Y ☐ N | Rheumatic fever | ☐ Y ☐ N |
| High or low blood pressure | ☐ Y ☐ N | Bleeding problem, bruises easily | ☐ Y ☐ N | Anemia or blood disorder | ☐ Y ☐ N |
| Diabetes | ☐ Y ☐ N | Thyroid condition | ☐ Y ☐ N | Asthma or breathing trouble | ☐ Y ☐ N |
| Seizures or epilepsy | ☐ Y ☐ N | Fainting or dizzy spells | ☐ Y ☐ N | Hepatitis or liver disease | ☐ Y ☐ N |
| Kidney disease | ☐ Y ☐ N | HIV or a weakened immune system | ☐ Y ☐ N | Cancer, chemotherapy or radiation | ☐ Y ☐ N |
| Osteoporosis or bone medicines | ☐ Y ☐ N | Arthritis or joint problems | ☐ Y ☐ N | Stomach trouble or eating disorder | ☐ Y ☐ N |
| ADHD, autism, learning differences | ☐ Y ☐ N | Anxiety about dental visits | ☐ Y ☐ N | Hearing or vision difficulty | ☐ Y ☐ N |
| Sinus trouble or hay fever | ☐ Y ☐ N | Tonsils or adenoids removed | ☐ Y ☐ N | Tobacco, vaping or nicotine use | ☐ Y ☐ N |
| Pregnant or nursing (adults) | ☐ Y ☐ N | Other condition (list below) | ☐ Y ☐ N | | |

Allergies or reactions to:

| | | | | | |
|---|---|---|---|---|---|
| Latex | ☐ Y ☐ N | Nickel or other metals | ☐ Y ☐ N | Penicillin or other antibiotics | ☐ Y ☐ N |
| Local anesthetic (numbing) | ☐ Y ☐ N | Aspirin, ibuprofen, codeine | ☐ Y ☐ N | Foods (which?) | ☐ Y ☐ N |

Details of any "yes" above | Needs an antibiotic before dental work? ☐ Yes ☐ No ☐ Not sure

Medications, vitamins and supplements taken regularly (including inhalers and birth control):

| Name | Dose, how often | Taken for |
|---|---|---|
| | | |
| | | |

## DENTAL

Last dental visit | Last dental X-rays | Brushes: ☐ 1× ☐ 2× a day | Flosses: ☐ Yes ☐ Sometimes ☐ No

Previous orthodontic treatment? ☐ Yes ☐ No | If yes: when, where, for how long | Wears a retainer now? ☐ Yes ☐ No

| | | | | | |
|---|---|---|---|---|---|
| Thumb or finger sucking (ever) | ☐ Y ☐ N | Nail biting, pen chewing | ☐ Y ☐ N | Breathes through the mouth | ☐ Y ☐ N |
| Snoring or restless sleep | ☐ Y ☐ N | Clenching or grinding | ☐ Y ☐ N | Jaw joint clicks or pops | ☐ Y ☐ N |
| Jaw pain, locking, tiredness | ☐ Y ☐ N | Frequent headaches | ☐ Y ☐ N | Injury to teeth, jaws or face | ☐ Y ☐ N |
| Missing or extra teeth | ☐ Y ☐ N | Teeth sensitive to hot or cold | ☐ Y ☐ N | Gums bleed when brushing | ☐ Y ☐ N |
| Trouble chewing or biting | ☐ Y ☐ N | Speech difficulty | ☐ Y ☐ N | Plays contact sports | ☐ Y ☐ N |
| Plays a wind instrument | ☐ Y ☐ N | Self-conscious about the smile | ☐ Y ☐ N | Family history of jaw or bite problems | ☐ Y ☐ N |

## WHAT BRINGS YOU IN

What would you like us to look at? Who noticed it: the patient, a parent, the dentist?

Interested in: ☐ Metal braces ☐ Clear braces ☐ Clear aligners (Invisalign) ☐ No preference yet | Timing: ☐ As soon as it makes sense ☐ Just checking for now

The answers above are accurate to the best of my knowledge. I will tell the office if the patient's health or medications change during treatment.

Signature of patient, or parent or guardian if the patient is under 18 | Date

Office use Reviewed by _____ Date _____ Alerts: _____

# Omerza Orthodontics

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## Consents & acknowledgments

Please initial each section · Today's date _____

Patient's name _____ Date of birth _____

### 1. NOTICE OF PRIVACY PRACTICES

_____ I have been offered a copy of the Omerza Orthodontics Notice of Privacy Practices, which explains how the patient's health information may be used and disclosed and how to get access to it. It is also at canton-orthodontist.com/forms/.

### 2. EXAMINATION AND DIAGNOSTIC RECORDS

_____ I consent to an orthodontic examination of the patient by Dr. Frank F. Omerza or the team working under the doctor's direction, and to the diagnostic records the examination may call for: photographs of the face and teeth, dental X-rays, and digital scans or impressions of the teeth. These records are used to diagnose and to plan, and they become part of the patient's chart. The examination does not commit me to treatment. Any treatment is explained first, with its fee and alternatives, and agreed to in writing separately.

### 3. HOW WE MAY REACH YOU

_____ You may: ☐ leave a voicemail ☐ send appointment reminders by text ☐ email me about appointments and the account. Text and email are not fully secure; we keep them to scheduling and general information unless you ask otherwise.

Besides a parent or guardian, you may discuss the patient's appointments, treatment and account with:

Name _____ Relationship _____ Name _____ Relationship _____

### 4. PHOTOGRAPHS FOR TEACHING OR PROMOTION

optional, and your care is the same either way

Apart from the diagnostic records in section 2, we sometimes show treatment results or office moments on our website, in our social-media posts, or in teaching. Choose one:

☐ Yes, you may use photographs and video of the patient for those purposes, with the first name only.

☐ Yes, but with no name at all.

☐ No, thank you.

A "yes" can be withdrawn at any time by telling the office in writing; we will stop using the pictures going forward.

### 5. FEES AND INSURANCE

_____ I understand that the fee for any treatment is quoted in writing before it starts, that it covers the treatment described, and that payment arrangements are agreed before the first appliance is placed. Insurance estimates are estimates: the plan pays what it pays, and the person responsible for the account is responsible for the rest. I authorize the release of the information needed to file claims; the office files them as a courtesy, and whether the plan pays me or the office, the fee remains my responsibility. If a payment is going to be late, I will call the office before it is missed.

Signature of patient (18 or over), or parent or guardian _____ Date _____

Printed name _____ Relationship to patient _____ Witness (office) _____