Omerza Orthodontics

Lorain 1740 Cooper Foster Park Rd W, Lorain, OH 44053 · (440) 960-2970

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