Welcome to Southwest Orthodontic Associates

Today's Date: _____

Name: _____ ❑ Male ❑ Female ❑ Prefer not to say Nickname: _____
First Middle Last

Address: _____
PO Box/Street Apt. No. City Zip

Age: ___ Birth Date: ___/___/___ Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced Cell Phone: _____

Names of other family members seen by us: _____ Email: _____

Special Interests: _____ Whom may we thank for referring you to our office? _____

Employer: _____ Occupation: _____ Work Phone: _____

DENTAL HISTORY

Dentist: _____ Last Dental Visit: _____

What concerns you most about your teeth? _____

Are you a mouth breather? Yes No

Have there been any injuries to face, mouth, or teeth? Yes No

Any type of thumb or finger sucking habit now or as a child? Yes No

Do teeth or jaws ever feel uncomfortable first thing in the morning? Yes No

Experience jaw clicking or popping? Yes No

Aware of any clenching or grinding during the day? Yes No

Experience "tension" headaches? Yes No

Have you completed any speech or tongue therapy? Yes No

Are you aware that some appointments will be during work hours? Yes No

MEDICAL HISTORY

Physician _____ Date of Last Visit _____

Do you have allergies? Yes No If yes, list them _____

History of a major illness? Yes No If yes, list them _____

Have you seen an ENT? Yes No Tonsils / Adenoids removed? Yes No

Have you had any other surgeries? Yes No If yes, list them _____

Ever been in a serious accident? Yes No If yes, list them _____

History of sleep apnea in the family? Yes No If yes, relationship to you? _____

***Female Patients Only:* Are you pregnant? Yes No**

Circle any of the medical conditions below that you have had or currently have.

Abnormal Bleeding / Hemophilia	Diabetes	Hepatitis/Liver Problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney Problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

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DENTAL INSURANCE

PRIMARY

Do you have orthodontic coverage? **Yes** **No**

Insured's Name: _____ Insured's Social Security #: _____

Insured's Employer: _____

Insured's Birthdate: _____ ID #: _____ Group #: _____

Insurance Company: _____ Payor ID #: _____

Insurance Company Address: _____ Phone: _____

Do you have dual coverage? Yes _____ No _____ If yes, complete secondary section below.

SECONDARY

Insured's Name: _____ Insured's Social Security #: _____

Insured's Employer: _____

Insured's Birthdate: _____ ID #: _____ Group #: _____

Insurance Company: _____ Payor ID #: _____

Insurance Company Address: _____ Phone: _____

Insured Relationship to Patient: _____

I understand that Southwest Orthodontics is not accepting certain insurances for example state issued. I have been informed I could seek treatment elsewhere that is accepting my insurance, however, I choose to continue treatment at Southwest Orthodontics. By doing so, I understand I waive my insurance benefit and will cash pay for treatment.

Signature of Patient: _____ ***Date:*** _____

EMERGENCY CONTACT

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Phone _____

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It is my responsibility to inform this office of any changes in my medical status.

I hereby authorize payment directly to Southwest Orthodontic Association of all orthodontic insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any deductible that my insurance does not cover. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Patient: _____ ***Date:*** _____