Welcome to Southwest Orthodontic Associates

Tell Us About Yourself **Today's Date:** _____

Name: _____ Male Female Nickname: _____
Last First MI

Home Phone # : (___)_____ Name Under Which Phone Is Listed: _____

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

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

Names of other family members seen by us: _____

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

Employer: _____ Work Phone #: (____)_____ Social Security #: _____

DENTAL HISTORY

Dentist: _____ Have you seen your dentist within the last six months? Yes No

How frequently do you brush your teeth? _____ Do you floss your teeth daily? Yes No

Have you seen an orthodontist before? Yes No

What were you told concerning your orthodontic problem? _____

What did you like most about any orthodontist you have seen? _____

Do / did you have any of the following habits?

Y N Chewing on Objects	Y N Mouth Breathing	Y N Speech Problems
Y N Clenching / Grinding Teeth	Y N Nail Biting	Y N Thumb / Finger Sucking
Y N Lip Sucking / Biting	Y N Popping and Clicking in Jaw	Y N Tongue / Cheek Biting

MEDICAL HISTORY

Physician: _____ Are you currently under the care of a physician? Yes No

Please explain: _____

Please describe your current physical health: Good Fair Poor

Please list all medications that you are currently taking: _____

Are you allergic to latex? Yes No Please list all other allergies: _____

Do you receive antibiotic pre-medication before dental procedures? Yes No

Do you use any tobacco products? Yes No

Do you have / have you experienced any of the following:

Y N Abnormal Bleeding	Y N Congenital Heart Defect	Y N High Blood Pressure
Y N Abnormal Blood Pressure	Y N Convulsions	Y N Low Blood Pressure
Y N Aids / HIV+	Y N Diabetes	Y N Mitral Valve Prolapse
Y N Anemia	Y N Epilepsy	Y N Rheumatic Fever
Y N Asthma	Y N Hearing Impairment	Y N Tuberculosis
Y N Cancer	Y N Hepatitis	Y N Severe Visual Impairment

Please discuss any other pertinent health problems you experience/ed: _____

_____

(CONTINUED ON BACK)

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relationship: _____

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

Work Phone #: (____)_____ Home Phone #: (____)_____ SS#: _____

Employer: _____ Length of Employment: _____

May we request a credit report for the responsible party? Yes No

INSURANCE INFORMATION

Do you have orthodontic coverage? Yes No If "yes" - Insurance Company Name: _____

Phone #: (____)_____ Group # (Plan or Policy #): _____

Company Address: _____
PO Box/Street City State Zip

Policy Owner's Name: _____ Relationship to Patient: _____

Policy Owner's Birth Date: ___/___/___ Social Security #: _____

Policy Owner's Employer: _____

Employer's Address: _____
PO Box/Street City State Zip

Do you have a Flex Pay / Cafeteria Plan? Yes No

Do you have secondary orthodontic coverage? Yes No (If so, please inform the receptionist.)

Medipass (Title XIX) Yes No

Patient Identification Number: _____ County: _____

Do you have secondary insurance coverage? Yes No (If so, please inform the receptionist.)

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.

_____ _____
Signature Date

I hereby authorize payment directly to Southwest Orthodontic Associates for 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 Date

_____ _____
Doctor's Signature Date

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