Welcome to Southwest Orthodontic Associates

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

Name: _____ Male Female Nickname: _____
Last First MI

Home Phone # : (___)_____ Cell Phone # : (___)_____ Email Address:_____

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

SOUTHWEST ORTHODONTIC ASSOCIATES, P.C.

CONFIDENTIALITY POLICY AND INSURANCE AUTHORIZATION

A: PRIVACY POLICY

Southwest Orthodontic Associates, P.C. maintains patient information concerning dental records and insurance in the strictest confidence. Please sign the release below, which allows us to share needed and relevant information with your insurance carrier. Your signature also allows us to provide dental information to other health care providers responsible for your care. Information will not be shared with any other party, without prior written approval, except where required by law.

B: AUTHORIZATION TO RELEASE INFORMATION

I authorize any holder of dental or other information about me, or parties for whom I am responsible, to release such information to the insurance carrier, for which I have provided information to Southwest Orthodontic Associates, P.C. or other party for purposes of processing this insurance claim. I permit a photocopy of this authorization to be used in place of the original.

C: AUTHORIZATION OF COMMUNICATIONS

I hereby authorize Southwest Orthodontic Associates, P.C. staff to call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operation, such as appointment reminders, insurance items and any call pertaining to my dental care. I also authorize Southwest Orthodontic Associates, P.C. to mail my home or other designated location, or e-mail my home or other designated location in a manner to assist in carrying out treatment, payment and healthcare operations.

D: ACKNOWLEDGEMENT OF PRIVACY RIGHTS

I acknowledge that the Southwest Orthodontic Associates "Notice of Privacy Practices" has been made available to me for review. I understand that Southwest Orthodontic Associates, P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Southwest Orthodontic Associates, P.C., Privacy Officer, 40 Northcrest Drive; Council Bluffs, IA 51503.

Signature of Patient (Or Legal Guardian) Date