ZWANZIGER & BOE
ORTHODONTICS

Welcome to Our Office!

PATIENT INFORMATION FOR ADULT PATIENTS (OVER 18 YEARS OF AGE)

Date _____

Patient's Name _____
Last First Middle

Address _____
Street City Zip

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____

Social Security # _____ Birthdate _____

Employer _____ Occupation _____

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

DENTAL INSURANCE INFORMATION

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

Insurance Company _____

Group No _____ Local No _____

Insurance Co. Address _____ Phone No _____

Do you have dual dental coverage? Yes_____ No_____ If yes, please complete the following:

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

Insurance Company _____

Group No _____ Local No _____

Insurance Co. Address _____ Phone No _____

Patient Signature _____ Date _____

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____

Complete address _____
Street City Zip

Phone _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? If yes, please list: _____
_____

Yes No Are you allergic to any medication? If yes, please list: _____
_____

Yes No Do you smoke? _____

Yes No History of a major illness? _____

Yes No Have you had any operations? _____

Yes No Ever been involved in a serious accident? _____

Yes No Have you seen a physician in the last 12 months? Why? _____

For Female Patients Only:

Yes No Are your pregnant? _____

Circle any of the medical conditions below that you currently have or have had in the past:

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? _____
_____

Patient Signature _____ Date _____

DENTAL HISTORY

General Dentist _____ **Date of last visit** _____

What concerns you most about your teeth? _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you presently in any dental pain? _____
Yes No Ever experienced any unfavorable reaction to dentistry? _____
Yes No Have you ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No Is any part of your mouth sensitive to temperature? Where? _____
Yes No Is any part of your mouth sensitive to pressure? Where? _____
Yes No Do gums bleed when brushing? _____
Yes No Any type of thumb or tongue habit? _____
Yes No Are you a mouth breather? _____
Yes No Have you ever seen an orthodontist? If yes, who and when? _____
What your attitude toward receiving orthodontic treatment? _____
Yes No Has anyone in the family received orthodontic treatment? _____
How did they feel about the result? _____
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 clenching or grinding teeth during the day? _____
Yes No Experience “tension” headaches? _____
Yes No Experience chronic ringing in the ears? _____
Yes No Does the patient need extra help with instructions? _____
Yes No Are you sensitive or self-conscious about your teeth? _____

BENEFITS, INFORMATION, AND CONSENT

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some changes after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions.

I understand that, where appropriate, credit bureau reports may be obtained.

Additionally, I agree to inform this office of any changes in my information, medical or dental histories, or dental insurance. In addition, I authorize Dr. Boe to perform a complete orthodontic evaluation.

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Patient Signature _____ Date _____

ZWANZIGER & BOE
ORTHODONTICS

"Signature on File" Authorization

Statement to Permit Payment of Any Health Insurance
Benefits to Supplier, Physician, or Patient

Name of Insured: _____

Name of Patient: _____

I understand and agree that I am responsible for the payment of any and all charges incurred as a result of this or any subsequent office visit(s). I also understand and agree to accept responsibility for payment of any and all claims should my insurance carrier deny all or part of a claim.

I understand and agree that all insurance deductibles and any incurred expenses not covered by the insured's health carrier must be paid for at the time of services.

I hereby authorize payment directly to Dr. Lucas S. Boe, for any services rendered to me by Dr. Lucas S. Boe or any of his authorized agents.

I authorize the release of all medical information to the insured's health insurance carrier that is:

1) acquired in the course of my examination or treatment and
2) which may have a bearing on the benefits payable under this or any other plan that provides benefits or services.

I authorize Dr. Lucas S. Boe or any of his authorized agents to assist me in obtaining payment from my health insurance companies.

I authorize a copy of this "Signature on File" form to be used in place of the original and that this copy may be used on all my insurance submissions.

_____ _____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE DATE

HIPAA Consent Form

Zwanziger & Boe Orthodontics
2302 West First Street #119
Cedar Falls, IA 50613

Patient Name:_____

HIPAA – Notice of Privacy Practices

HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practices is to explain how Zwanziger & Boe Orthodontics may use or disclose your health care information. The Notice also explains the rights that you are guaranteed under HIPAA regulations. Though Zwanziger & Boe Orthodontics has always taken great care to protect the integrity and confidentiality of your health care information, we are now required by the HIPAA Privacy Rule to distribute this notice to you and obtain acknowledgement that you have received the Notice. Our Notice of Privacy Practices is available for you to view on our website, www.zbortho.com, or a copy can be obtained by contacting our office. Signing below indicates that you have had the opportunity to review the Notice of Privacy Practices.

I certify that I have had the opportunity to review the Notice of Privacy Practices of Zwanziger & Boe Orthodontics.

Name of Responsible Party_____

Relationship to Patient_____

Signature_____

Date_____