SOUTHWEST IOWA DENTAL ASSOCIATES

1213 W. Nishna Rd. * Shenandoah, Iowa 51601 * (712)-246-2180

PATIENT INFORMATION

Patient Name* *Last* ____________________________ *First* ___________________ *MI*___ *Preferred* _______________

DOB* _____ /_____ / _________ ☐ Male ☐ Female ☐ Other **SSN*** _______-_______-________

Family Status *(optional)* ☐ Married ☐ Single ☐ Child ☐ Other

Mailing Address* *Street* ____

City _______________________________ , *State* _______ *Zip* __________

Phone* *Appointments confirmed by text* (______) ______-__________ ☐ Home ☐ Cell ☐ Work

(______) ______-__________ ☐ Home ☐ Cell ☐ Work

E-mail* *Statements sent by e-mail* ____@________________.com

Emergency Contact Name* ______________________________ **Phone*** (______) ______-__________

(<18 years) Mother's Name* ______________________________ **DOB*** _____ /_____ / _________

(<18 years) Father's Name* ______________________________ **DOB*** _____ /_____ / _________

INSURANCE INFORMATION

***Please provide your insurance card to the front desk.**

PATIENT AGREEMENT

APPOINTMENT POLICY

Southwest Iowa Dental Associates (SWIDA) kindly requests that I appear for my scheduled appointments on time or reschedule by giving a **24-HOUR NOTICE OF CANCELLATION**. I understand that proof of emergency may be requested. SWIDA reserves the right to charge a **$40.00 MISSED APPOINTMENT FEE PER PATIENT PER APPOINTMENT** for any missed appointments or appointments cancelled within 24 hours. No appointments will be scheduled until the fee is paid and upcoming appointments will be removed from the schedule.

SWIDA reserves the right to **DISMISS** a patient or family from the practice after **TWO (2) MISSED APPOINTMENTS**.

PAYMENT POLICY

Southwest Iowa Dental Associates (SWIDA) kindly requires **PAYMENT IN FULL DUE AT TIME OF SERVICE.** SWIDA reserves the right to assess a **22% FINANCE CHARGE PER MONTH ON ACCOUNTS 90 DAYS PAST DUE.** I understand that additional charges may be applied for accounts sent to collections. SWIDA will continue to submit to most insurances on my behalf as a courtesy, however **SWIDA DOES NOT GUARANTEE PAYMENT ON MY INSURANCE PROVIDER'S BEHALF** for any procedures. For any over-payments, SWIDA will offer me a refund by check or a credit to my account.

RELEASE OF INFORMATION WAVIER (Available upon request)

I have had the opportunity to complete this waiver which instructs parts of my file be released to a third party of my naming.

LEGAL GUARDIANSHIP / POWER OF ATTORNEY (Available upon request)

I have had the opportunity to inform SWIDA if I am a person legally named in a court of law as having authority over the health care of the patient so named above. I have supplied SWIDA with legal documentation.

GENERAL CONSENT FOR TREATMENT

I authorize the doctor(s) and staff to perform all necessary x-rays, tests and exams that may be useful for the diagnosis of the oral cavity and associated structures, and to recommend treatment as indicated. I may decline or accept recommended treatment and will inform my provider of desired changes prior to treatment. SWIDA agrees to provide appropriate treatment to the best of our ability in a timely manner.

NOTICE OF PRIVACY PRACTICE (HIPAA)

Please refer to laminated addendum (yellow page) for full HIPAA notice.

I have accurately provided SWIDA with my PATIENT INFORMATION and INSURANCE INFORMATION.
I have had an opportunity to read and ask questions about the PATIENT AGREEMENT and the NOTICE OF PRIVACY PRACTICE (HIPAA).

Signature ____ Today's Date _____/______/___________