Cherry Creek
OROFACIAL MYOLOGY

CHERRY CREEK OROFACIAL MYOLOGY
PATIENT REGISTRATION FORM

GENERAL INFORMATION

Name (First, M.I, Last) _____Nick Name _____
Social Security Number_____ Date of Birth_____
Address_____ Home Phone_____ Cell_____
City_____ State_____ Zip_____E-mail_____
Occupation_____
Employer_____Work Phone_____
Check __Single __Married __Divorced __Widowed __Separated
If married, spouse's name_____
Person financially responsible (First, M.I., Last)_____
Relationship to patient_____ Social Security Number_____
___Address is the same as above (If different, please provide the following information)
Address_____ Home Phone_____
City_____ State_____ Zip_____
Person to contact for emergency_____ Phone_____
School Attending_____Grade_____
Dentist_____ Phone_____
Orthodontist_____ Phone_____
Physician_____ Phone_____
Speech Pathologist_____ Phone_____
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

INSURANCE

Do you have dental insurance? Yes No
Do you have medical insurance? Yes No

Your insurance is a contract between you and your insurance company. While we will help you collect the maximum benefits owed to you, our responsibility is to assess, examine, diagnose, evaluate and provide the highest quality treatment for your orofacial muscular and oral motor health needs. We request direct payment since insurance is considered reimbursement to the patient. Our insurance is filed under the medical side. While your initial referral may have come from your dentist, we have found that having a medical referral from your physician is beneficial when filing your insurance. We will provide you with an initial evaluation report and request for you to take to your doctor and ask for this referral. If you have any questions concerning specific details of coverage for your plan, it is most effective if you contact your company directly.

Primary Medical Carrier
Insurance Holder's Name (First, M.I., Last) _____
Patient's Relationship to Insured: Self Spouse Child Other
Insured Employer_____
Insurance Holder's Social Security Number_____ Insurance Holder's DOB_____
Insurance Company_____Policy Number_____
Union or Local Number_____Employee Number_____
Group Number_____ Electronic ID Number_____

**If you have secondary insurance, we will provide you with an itemized receipt so you may submit you secondary insurance claim along with the explanation of benefits from your primary insurance carrier.*

CHERRY CREEK OROFACIAL MYOLOGY
PATIENT REGISTRATION FORM (cont'd)

CONSENT

1. I authorize the therapist or designated staff to take study models, photographs and any other diagnostic aids deemed appropriated by the therapist to make a thorough diagnosis of my orofacial myofunctional needs.

2. I give permission for use of photographs and records made in the process of examination and treatment to be used for the purposes of research, education and publication in professional journals.

3. Upon such diagnosis, I authorize the therapist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care, including the exchange of medical information between my providers and my insurance company.

4. I consent to the use of appropriate therapy as deemed necessary. This includes the use of "spots" (stomahesive) or palatal reference material for proper tongue placement either on myself or the minor/patient in care by guardian listed below. More information is available upon request as to the composition of this material.

5. It must be noted that successful completion of the myofunctional therapy program is dependent upon patient desire, good attitude and self-discipline. Parental involvement and encouragement are important and necessary when working with children.

6. One of the goals of orofacial myology therapy is the achievement of a closed mouth resting posture. A clear airway is necessary in order to reach this goal. Patients who have allergies or related nasal airway problems present a higher risk that goals may not be attained or may require additional visits to do so.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE POLICY

PATIENT/ PARENT/ GUARDIAN SIGNATURE _____

DATE _____