Adult copy

Today's date:_____ Name:_____
Date of birth:_____ Sex: Male or Female
Address:_____
City:_____ State:_____ Zip:_____
Home#:_____ Mobile#:_____
Email address:_____
Employer:_____ Work#:_____

Primary insurance:

Policy holder's name:_____ Date of birth:_____
Name of insurance:_____ Employer name:_____
SSN:_____ ID#:_____Group #_____

Secondary Insurance:

Policy holder's name:_____ Date of birth:_____
Name of insurance:_____ Employer name:_____
SSN:_____ ID#:_____ Group#:_____

Dental History:

Dentist Name:_____
When was your last exam and cleaning? Yes or No
1.Do your gums bleed when you brush? Yes or No
2.Have you ever been told that you have Periodontal Disease? Yes or No
3. Are you currently seeing a Periodontist for your cleanings? Yes or No
4.Do you have any clicking, popping or pain in the jaw point? Yes or No
5. Do you clench or grind your teeth? Yes or No
6.Do you have any problems opening or closing your mouth? Yes or No
7.Have you ever injured or had trauma to your teeth, face or jaw? Yes or No If yes, please explain:_____
8. Have you ever had prior orthodontic treatment in the past? Yes or No If yes, do you have a retainer that you are still wearing? Yes or No
9.Are your wisdom teeth still present? Yes or No
10.Are you interested in whitening your teeth? Yes or No
11. Have you been advised by your physician to take an antibiotic prior to dental treatment? Yes or No
If yes, please explain_____
12.Is there dental work that is in progress or needs to be completed? Yes or No

13.What is your main concern about your teeth?

_____

14.Would you like to see facial appearance with orthodontics? Yes or No If yes, please explain_____

15.Are you interested in braces? Yes or No Invisalign? Yes or No

Medical History

Physician's Name:_____

1.Do you have health problems, disorders or conditions? Yes or No If yes, please explain_____

2. Are you allergic to any medications? Yes or No If yes, please list:_____

3.Allergic to LATEX? Yes or No Environmental: (Dust, Pollen, Mold) Yes or No

4. Medications that you are currently taking:_____

5. Are there any facial features that you would like to see after completing orthodontic treatment? Yes or No If yes, please list:_____

Patient's Health History:

Birth problems…… Yes or No	Emotional or Behavior problems…….. Yes or No
Speech problems…… Yes or No	Hearing problems…….. Yes or No
Tonsils/Adenoid problems Yes or No	Growth problems…… Yes or No
Attention Deficit Disorder…..Yes or No	Heart Murmur…….. Yes or No
Diabetes…….. Yes or No	Rheumatic Fever…… Yes or No
Arthritis…… Yes or No	Anemia…….. Yes or No
Cancer…… Yes or No	Radiation Therapy…….. Yes or No
Sickle Cell Anemia……..Yes or No	Cerebral Palsy…….. Yes or No
Bleeding or Hemophilia……..Yes or No	Seizures…….. Yes or No
Blood Transfusions……..Yes or No	Asthma…….. Yes or No
Hepatitis……..Yes or No	Cleft Lip or Palate…….. Yes or No
AIDS or HIV+ ……Yes or No	Eye problems…… Yes or No
Tuberculosis…… Yes or No	Liver Disease…….. Yes or No
Sleep Apnea…… Yes or No	Kidney Disease…… Yes or No
Osteoporosis…… Yes or No	Skin problems…….. Yes or No

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

Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email address, home address, social security numbers, and demographic data) may be used or disclosed us in one or more of the following respects:\

- To other care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleaning, surgery, etc.)
- To third party payers or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payments, etc.)
- To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in your treatment;
- To other patients and third parties who may see or over hear incidental disclosure about your treatment, scheduling, etc.;
- To your family and close friends involved in your treatment; and/or,
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restriction on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information though asking us;
- Amend or modify your protected health information in certain circumstances
- Receive an accounting of certain disclosures made by us of your protected health information; and.
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquires to our Privacy Contact Person at our office address) or the Unites States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practice with respect with such information;
- To abide by the terms of our Privacy Notice that is currently in effect;

- To advice you of our rights to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

PATIENT ACKNOWLEDGMENT

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

_____ _____

Patient/Guardian Signature Date

Informed Consent

State law requires professionals to provide their prospective patients with information regarding the treatment they are considering. Informed consent indicates your awareness of information, which includes the negative, as well as the positive aspects of orthodontic treatment.

In the vast majority of orthodontic treatment cases, significant improvement can be achieved with informed and cooperative patients. While the benefits of a pleasing smile and healthy teeth are considered necessary by most people, orthodontic treatment is normally an elective procedure and it, like many other treatment of the body, has certain inherent risks and limitations. These risks seldom contraindicate treatment, but should be considered before beginning treatment. You may have my assurance that even though informed consent is a legal requirement; I will endeavor to keep these negative possibilities of orthodontic treatment to a minimum.

PATIENT COOPERATION Lack of cooperation is the most common cause that affects the quality of treatment results. Oral hygiene, proper elastic and headgear wear, care of appliances, and the keeping of regular appointments are the most important factors in eliminating lengthened treatment time and compromised results. Routine visits to your dentist are an important part in orthodontic treatment or transfer to the care of another orthodontist.

AUXILLARY PERSONNEL Due to the nature of orthodontic treatment much of the appliance adjustment may be performed by well-trained auxiliary personnel.

ADDITIONAL FEES Additional fees may be required for procedure not specifically outlined in your orthodontic contract.

DECALCIFICATION, TOOTH DECAY AND GUM DISEASE Excellent oral hygiene, elimination of hard sticky foods, and the reduction of sweets will help prevent tooth decay and permanent of discoloration of the teeth. Reporting loose bands or broken appliances quickly will help minimize decay and gum problems.

CBCT/XRAYS 3D Cone Beam Computer Tomography CBCT allows for increased diagnostics information. Any X-rays has risks, however, diagnostic information gained from these studies typically overweighs the risks. Our goal is to keep these x rays as low as reasonably possible. X rays are billed as “diagnostics records fee” and may be billed to you and your insurance.

NON-VITALOR DEAD TOOTH A tooth that has been traumatized by a blow or other causes can die over a long period of time with or without orthodontic treatment. This tooth may flare up during treatmentand require endodontic treatment (root canal).

ROOT RESORPTION This is the shortening of the root tips and can occur with or without orthodontic treatment. Trauma, impaction, endocrine disorders or idiopathic (unknown) reasons can cause this problems.

TEMPROMANDIBULAR JOINTS (TMJ) In some instants the patient may have problems with the joint of the lower jaw. This may exist before, during and after treatment. Tooth alignment generally can improve TMJ problems, but not in all cases.

GROWTH PATTERN Unusual or undesirable skeletal growth can affect final orthodontic results. Surgical assistance is often recommend is these cases.

POST-TREATMENTTOOTH MOVEMENT (RELAPSE) Teeth have a tendency to return to their original position, which is called relapse. Rotation and crowding of the lower front teeth, slight spacing in extraction sites or between the upper centrals incisors are the most common examples. Very severe problems have a tendency to relapse. Teeth shift during the lifetime of any individual with or without orthodontic treatment, but proper retainer wear can minimize this problem. Because of the possibility of relapse, the patient should contact the orthodontist for examination whenever a change in tooth structure or alignment is noted by the patient or other dental team member and, in any event at least every 2 years.

HEADGEAR OR RETRACTOR Instructions should be followed carefully. Headgear that is pullout outward while the elastic force is attached can snap back and cause injury.

IMPACTED TEETH Especially cuspids and third molars (wisdom teeth) can cause problems which may lead to loss of teeth, gum problems or relapse.

BONE LOSS Occasionally tooth movement aggravates bone loss, but this is rare.

PAIN AND DISCOMFORT Usually there is a short period of discomfort following each appointment, which some patients experience more than others. Should responsible party agree to treatment, responsible party consents to the taking of photographs and x rays before, during and after treatment, and to the use of the same by the orthodontist in scientific papers and demonstrations. No practitioner of medicine or dentistry can guarantee any results but the orthodontist agrees to use all reasonable efforts to resolve the orthodontic problems of the patient as diagnosed. This form requires the signature of the responsible party, which authorizes orthodontic treatment as well as defining the financial responsibilities and awareness of informed consent bt the responsible party.

ALAN A. CURTISDDS MS

ORTHODONTIST

The undersigned acknowledge that the undersigned has read the above information, understands same and consents to the orthodontic treatment for the patient by the orthodontist.

Date_____**Patient**_____ **Responsible Party**_____