
## Child copy

Today's date:_____ Child's Name:_____

Nickname_____ Date of birth:_____ Sex: Male or Female

Address:_____

City:_____ State:_____ Zip:_____

Home#:_____ Name of School:_____

Are mother and father divorced or live in separate households? Yes or No

## Parent Information:

Father's name:_____ Date of birth:_____

Email address:_____Mobile#:_____

Address if different from patient:_____

Mother's name:_____ Date of birth:_____

Email address:_____Mobile#:_____

Address if different from patient:_____

## Primary insurance:

Policy holder's name:_____ Date of birth:_____

Name of insurance:_____ Employer name:_____

SSN:_____ ID#:_____Group #_____

Insurance Phone #:_____

## Secondary Insurance:

Policy holder's name:_____ Date of birth:_____

Name of insurance:_____ Employer name:_____

SSN:_____ ID#:_____ Group#:_____

**Dental History:**

Dentist Name:_____

When was your child's last exam and cleaning? Yes or No

1.Do your child's gums bleed when you brush? Yes or No

2.Has your child ever been told that they have gingivitis? Yes or No

3.Does your child have any clicking, popping or pain in the jaw point? Yes or No

4. Does your child clench or grind your teeth? Yes or No

5.Does your child have any problems opening or closing your mouth? Yes or No

6.Has your child ever injured or had trauma to your teeth, face or jaw? Yes or No If yes, please explain:_____

7. Has your child 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

8. Has your child been advised by your physician to take an antibiotic prior to dental treatment? Yes or No If yes, please explain_____

9.Is there dental work that is in progress or needs to be completed? Yes or No

10.What is your main concern about your child's teeth?

**Medical History**

Physician's Name:_____

1.Does your child have health problems, disorders or conditions? Yes or No If yes, please explain_____

2. Is your child 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 your child is currently taking:_____

5.Is it okay to discuss your child's facial appearance, extractions, appliances, treatment while present? Yes or No

6.Does your child suck their thumb? Yes or No

7. Did they suck their fingers or thumb in the past? Yes or No IF yes, how long ago did they stop?_____

**Child'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 treatment and 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 cupids 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 to 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**_____