Patient Information Form

Patient Name: ______________________________ Today's Date: ______________

Preferred Name: ______________ Email: ______________________________

Date of Birth: __________ Age: ____ Cell Phone: ____________ Home Phone: ______________

Address: __________________ City: ____________ State: ______ Zip: __________

Employer: ___________________ School: __________________ Grade: ________

Who else have we treated in your family? ______________________________

How did you year about our office or who referred you? ______________________________

Responsible Party: ______________________________ Date of Birth: ______________

Relationship to Patient: ______________________ Marital Status: ☐ Single ☐ Married ☐ Divorced

Cell Phone: ____________ Home Phone: ______________ SSN: ______________

Address: __________________ City: ____________ State: ______ Zip: __________

Employer: __________________ Work Phone: ____________ Email: ______________

Spouse or Other Parent: ______________________________ Date of Birth: ______________

Relationship to Patient: ______________________ Marital Status: ☐ Single ☐ Married ☐ Divorced

Cell Phone: ____________ Home Phone: ______________ SSN: ______________

Address: __________________ City: ____________ State: ______ Zip: __________

Employer: __________________ Work Phone: ____________ Email: ______________

Primary Dental Insurance

Name of Insurer: ______________________ Group Name: ______________________

Name of Primary Person Covered by this Insurance: ______________________________

Date of Birth of Primary Person: ______________________ SSN: ______________________

Secondary Dental Insurance

Name of Insurer: ______________________ Group Name: ______________________

Name of Primary Person Covered by this Insurance: ______________________________

Date of Birth of Primary Person: ______________________ SSN: ______________________

Tertiary Dental Insurance

Name of Insurer: ______________________ Group Name: ______________________

Name of Primary Person Covered by this Insurance: ______________________________

Date of Birth of Primary Person: ______________________ SSN: ______________________

Emergency Contact

Name: __________________ Relationship: ____________ Phone: ______________

Confidential Patient Medical and Dental History

Physician's Name: ______________________ Phone: ______________ Last Visit: __________

Has patient ever been under the extended care of a physician or had any surgeries? ☐ Yes ☐ No

If yes, please explain: ____

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

☐ Heart Conditions (murmur, etc.)	☐ HIV Positive	☐ Hepatitis
☐ Excessive Bleeding	☐ Tuberculosis	☐ Frequent Headaches
☐ Diabetes	☐ Asthma	☐ Kidney Infections
☐ Rheumatic Fever	☐ Epilepsy	☐ Cerebral Palsy
☐ Liver Problems	☐ Birth Defects	☐ Eyesight Problems
☐ Cancer	☐ Infections	☐ Speech Impairments
☐ Nervous Disorders	☐ ADHD	☐ Autism

☐ Other ____

Is the patient currently on any medications? ☐ Yes ☐ No If yes, list: ______________________

Is the patient allergic to any foods or medicines? ☐ Yes ☐ No If yes, list: ______________________

Is the patient allergic to any plastics or metals? ☐ Yes ☐ No If yes, list: ______________________

Is the patient taking or has the patient taken Bisphosphonates (e.g. Fosomax)? .... ☐ Yes ☐ No

Does the patient need to be medicated prior to dental appointments? .... ☐ Yes ☐ No

Have tonsils or adenoids been removed? .... ☐ Yes ☐ No

Women: Are you pregnant? .... ☐ Yes ☐ No

DENTAL AND ORTHODONTIC HISTORY

General Dentist (name of office): ____________________ Approximate date of last dental cleaning __________

Is there any dental work to be completed? (Fillings,crowns, etc.).	☐Yes	☐No	______________
Have there been any injuries to the face, mouth, or teeth?	☐Yes	☐No	______________
Has the patient ever sucked their fingers or thumb?	☐Yes	☐No	Until what age? ________
Does the patient have any speech problems?	☐Yes	☐No	______________
Is the patient a mouth breather while asleep or awake?	☐Yes	☐No	______________
Have you been informed of any missing or extra permanent teeth?	☐Yes	☐No	______________
Is there pain/popping/clicking in the jaw joint?	☐Yes	☐No	When did this begin? ______
Does the patient clench or grind?	☐Yes	☐No	______________
Does the patient regularly have headaches?	☐Yes	☐No	______________
Does the patient gag easily?	☐Yes	☐No	______________
Has the patient ever had orthodontic treatment?	☐Yes	☐No	______________
Has the patient ever had a previous orthodontist exam?	☐Yes	☐No	______________
Have any family members had orthodontic treatment?	☐Yes	☐No	______________

What is the chief concern that brought you to our office? ______________________________

____

I certify that the above information is complete and accurate.

Parent/Guardian Signature ______________________ Date __________

Dentist Signature ______________________ Date __________

Informed Consent in Orthodontics

DEAR PARENT/PATIENT:

As a rule, an informed and cooperative patient can achieve excellent orthodontics results. Thus, the following information is routinely supplied to anyone considering orthodontic treatment in our office. While recognizing the benefits of a pleasing smile and healthy teeth, you should also be aware that orthodontic treatment, like any treatment of the body, has inherent risks and limitations. These are seldom enough to contradict treatment but should be considered in deciding to wear orthodontic appliances.

Perfection is our goal. However, in dealing with human beings and growth and development problems, genetics, and patient cooperation, achieving perfection is not always possible. Often a functionally and esthetically adequate result must be accepted.

Throughout life, tooth position is constantly changing. This is true with individuals regardless of whether they have had orthodontic treatment or not. Post-orthodontic patients are subject to the same subtle changes that occur in non-orthodontic patients. We recommend that you always keep your retainers to maintain our achieved orthodontic results.

Decalcification (permanent marketing), decay, or gum disease can occur if patients do not brush their teeth thoroughly and adequately during treatment. Excellent oral hygiene and plaque removal are a must. Sugars and between meal snacks should be minimized.

On rare occasions, the nerve of a tooth may become non-vital. A tooth traumatized from a deep filling or even a minor blow can die over a long period with or without orthodontic treatment. An undetected non-vital tooth may flare up during orthodontic movement requiring endodontic (root canal) treatment to maintain it.

In some cases, the root ends of the teeth are shortened during treatment. This is called resorption. Under healthy circumstances, the shortened roots are at no disadvantage. However, in the event of gum disease later in life, root resorption could reduce the longevity of the affected teeth. Patients should note that not all root resorption arises from orthodontic treatment. Trauma, cuts, impactions, endocrine disorders, or idiopathic reasons can cause root resorption.

There is also a risk that problems may occur in the temporomandibular joints (TMJ). Although this is rare, it is possible. Tooth alignment or bite correction can improve tooth-related causes of TMJ pain but not in all cases. Tension appears to play a role in the frequency and severity of joint pain.

Patients must follow headgear instructions carefully. A headgear pulled outward while elastic force is attached can snap back and poke into the face or eyes. Be sure to release the elastic pressure before removing the headgear.

The total time for treatment can be delayed beyond our estimate. Disproportionate facial growth, atypical formation of teeth, poor elastic wear or headgear cooperation, broken appliances, and missed appointments are all important factors that can lengthen the treatment time and affect the quality of the result.

Damage to a tooth's enamel or to a restoration (crown, bonding, veneer, etc.) is possible when orthodontic appliances are removed. If damage to a tooth or restoration occurs, treatment by your general dentist may be necessary.

I have read and fully understand the above.

Signature of Parent/Guardian, or Patient: ______________________________

Relationship to Patient: ______________________________ Date: ______________

General Consent and Practice Policy

The doctors and staff at this practice have an unwavering commitment to the patient's superior oral health. We use scientific and ethical principles in order to provide our patients with the highest standard of orthodontic care. We also recognize that creating a fun, friendly, and comfortable environment is critical to a patient's long-term oral health. We know you have a choice in orthodontic providers and we hope that these goals are the primary reason you have chosen our practice. Please keep in mind that all of the following policies center on accomplishing these two core philosophies.

• **Payment/Insurance Policy:** Payment in full is die at the time of service. We accept all major credit cards, cash, or personal checks. We cannot guarantee any estimated coverage when billing insurance. Patients are responsible for determining if their insurance is contracted for the services that will be provided. Patients are responsible for all balances imposed by their insurance. You are ultimately responsible for any remaining amount unpaid by insurance. There will be a $50 service fee on any returned check. All unpaid balances are subject to a 10% processing fee and may incur a 1.5% monthly finance charge. All delinquent balances must be paid prior to incurring any new charges. Patients are responsible for determining whether or not our providers are considered to be a part of their insurance's network and will be responsible for all balances imposed by their insurance company. Any service overpaid will automatically be refunded to the patient's original payment method within 60 days. Checks will be issued within 60 days from the payment date for patients who made a cash payment.

• **Missed or Canceled Appointment Policy:** Due to the busy nature of our practice and as a common courtesy to the doctors and staff who are providing care to you or your child, we as that you please make your appointment/child's appointment a top priority. If you are unable to make the scheduled appointment please give us sufficient time to fill the appointment with another patient waiting to see our orthodontist. We as that you call to reschedule or cancel 24 hours in advance. A second last minute cancellation or no-show will lead to the end of the doctor-patient relationship. If you miss or break your appointment with less than 24 hours' notice, you may be subject to a $50-$100 cancellation fee.

• **Late Appointment Policy:** We ask that patients/parents make special effort to be at all scheduled appointments on time in order to minimize the impact on their care and experience as well as that of those patients scheduled later in the day. If a patient is more than 10 minutes late to a 30 minute appointment or 15 minutes late to a 60 minute appointment they may be required to reschedule or wait while we are for those patients who were on time to their appointments. Regular tardiness will lead to the end of the doctor-patient relationship.

• **Consent to Treat Policy:** I give my permission for the practice to perform orthodontic procedures including nitrous and local anesthetic within the professional scope of dentistry deemed as necessary on me/child's to individuals with my permission.

- Acknowledge the understanding that orthodontics is not an exact science and hereby request and authorize whatever the provider deems advisable if any unforeseen condition arises in the course of these designated treatment(s) and/or proce dures calling, in their judgment, for procedures in addition to or different from those contemplated. In addition, I have provided as accurate and complete medical history as possible including those antibiotics, drugs, medications, and foods to which my child is allergic.
- I give my permission to the following individuals to bring in my child/children to the practice for their appointments that may include any and all dental procedures.

• **Communication Policy:** Our top priority is to give you all the information needed to make informed decisions in regards to you/your child's oral health. This includes providing you with the nature of recommended procedures, the risks of those procedures, any alternatives to the procedures recommended, and an estimate of the costs involved to perform those procedures. We hope that open communication is important to you as well and that any concerns you have about treatment or our policies will be brought immediately to our attention with the same courtesy and respect. We will sincerely do all we can to develop a long-term relationship where your child's oral health and dental experience is number one for both of us.

• **Communication from Bluetree Brands:** I give consent to receive relevant communication from Bluetree brands and its affiliated partners.

• **Social Media/Phone Consent:** I give consent to use images taken of me/my child to showcase the extraordinary care we have received. Images may be posted on any/all social media platforms and our website.

Parent/Guardian's Signature ____________________ Date ____________________

Printed Name ____________________ Relationship to Patient ____________________

Patient/Parent Name ____________________ Date ____________________

Signature ____________________

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You may refuse to sign this acknowledgment**

By signing below, I am stating that I have received a copy of this office's Notice of Privacy Practices:

____

Please Print Patient Name

____

Signature of Patient/Legal Guardian

____

Date

You may communicate with the following individuals relating to the patient's medical or payment information:

FOR OFFICE USE ONLY

An attempt to obtain written acknowledgment of Receipt of our Notice of Privacy Practices was attempted, however acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

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