Patient Information

Date_____

Patient's name _____
Last First Middle

Address _____
Street City Zip

Home Phone_____ Cell Phone_____ Would you like a text? Yes No

Email_____ Birthdate_____Social Security _____

Interests_____ School_____

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

Responsible Party Information

Name _____
Last First Middle

Address _____
Street City Zip

Home Phone_____ Cell Phone_____ Would you like a text? Yes No

Email_____ Birthdate_____ Social Security _____

Relationship to Patient _____ Employer_____Occupation_____

Spouse's name _____
Last First Middle

Address _____
Street City Zip

Home Phone_____ Cell Phone_____ Would you like a text? Yes No

Email_____ Birthdate_____ Social Security _____

Relationship to Patient _____ Employer_____Occupation_____

Dental Insurance Information

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No. _____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No. _____

Emergency Information

Name of nearest relative not living with you Name_____ #_____

Please list 3 additional contact numbers : Name_____ #_____

Name_____ #_____

Name_____ #_____

Please list 1 additional email Name_____ _____

Permission to Use Photograph & Records

I, do hereby relinquish any and all rights to photographs, portraits,transparencies, negatives, prints, Polaroids or other photographic reproductions captured with still, motion picture, video, digital or other cameras for use by Taft Hill Orthodontics publicity, illustration, advertising, and Web content and or marketing. .

_____ _____

Signature Date

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____

Please circle Yes or No

Yes	No	Are you taking any medication?	Yes	No	Are you allergic to LATEX (gloves, ballons)?
Yes	No	Are you allergic to any medication?	Yes	No	Are you allergic to METALS (jewelry, clothing)?
Yes	No	Do you have a history of a major illness?	Yes	No	Have you had any major operations?
Yes	No	Do you smoke or chew tobacco?	Yes	No	Have you ever been involved in a serious accident?

IF YOU ANSWERED YES TO ANY QUESTION PLEASE GIVE DETAILS:

_____
_____
_____

GIRLS ONLY

Yes No Have you started your monthly periods? If so, approximately when? _____
Yes No Are you pregnant? If so, how long?_____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of?_____
_____

DENTAL HISTORY

Dentist _____ Date of last visit_____
What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain?_____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have you ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth or teeth? _____
Yes No Is any part of your mouth sensitive to temperature or pressure? _____
Yes No Do your gums bleed when you brush? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Are you a mouth breather?_____
Yes No Have you ever seen an orthodontist? If yes, who and when? _____
Yes No Would you object to wearing orthodontic appliances (braces) should they be indicated? _____
Yes No Has anyone in your family received orthodontic treatment? _____
How did they feel about the result? _____
What is your attitude toward receiving orthodontic treatment? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
Yes No Are you aware of your jaw clicking or popping?_____
Yes No Are you aware of clenching your teeth during the day? _____
Yes No Have you ever been told that you grind your teeth? _____
Yes No Do you have “tension” headaches? _____
Yes No Have you ever experienced chronic ringing in your ears? _____
Yes No If the patient is under age 16, height of parents? Mom_____ Dad_____
Yes No Are you aware that some appointments will be during school/work hours? _____

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph, I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Hardy to perform a complete orthodontic evaluation.

_____ _____
Signature **Date**

Potential Risks and Limitations of Orthodontic Treatment

All forms of medical and dental treatment, including orthodontics, have some inherent risks and limitations. They should be considered when making the decision to undergo orthodontic treatment. Some drawbacks are as follow:

PATIENT COOPERATION – THE MOST IMPORTANT FACTORIN COMPLETING THE TREATMENT ON TIME.

Perfection is always our goal, however, insufficient wearing of appliances (headgear, elastics, removable braces), broken appliances, broken or missed appointments, and poor oral hygiene, all contribute to increasing treatment time and compromise treatment results.

DECALCIFICATIONS – TOOTH DISCOLORATION.

Orthodontic appliances do not cause cavities, but because of their presence, food particles are retained more readily and the cavity potential is thereby increased. White marks, or signs of decay, can be prevented with proper diet, good tooth brushing habits and regular dental checkups. For this reason daily fluoride rinses are also recommended to help prevent these problems. Furthermore, a loose band or bracket greatly increases the potential of a cavity forming and should be reported as soon as possible.

PERIODONTAL PROBLEMS – SWOLLEN, BLEEDING GUMS AND PERIODONTAL DISEASE.

Swollen, inflamed and bleeding gums can be controlled or prevented by flossing and brushing of the teeth and gums. Accumulated bacterial plaque tends to irritate the gums and must be removed. If the health of the gums is not controlled by proper home care, it may be necessary to consult a gum specialist or periodontist. In rare cases (usually adults with pre-existing periodontal disease) it may be necessary to discontinue treatment until the gums return to a healthy state.

ROOT RESORPTION – SHORTENING OF ROOT ENDS.

The roots of teeth can become shorter with or without orthodontic treatment. Under healthy conditions the shortened roots usually are not a problem. However, excessive shortening could curtail treatment and there is a possibility of losing such teeth.

NONVITAL TOOTH – USUALLY RESULT FROM A PREVIOUS INJURY TO THE TOOTH.

The nerve of an injured tooth can die over a period of time with or without orthodontic treatment. This tooth could flare up or become discolored during treatment and would then require root canal treatment to save it. Orthodontic movement of the tooth would stop until the root canal treatment is completed. Devitalization is seldom due to orthodontics.

IMPACTED TEETH –TEETH UNABLE TO ERUPT NORMALLY.

The cuspid tooth, for example, is a commonly impacted tooth. More involved orthodontic treatment is needed to successfully move an impacted tooth into proper position. Additional information about this topic will be provided if necessary.

INJURIES FROM APPLIANCES – ALLERGIES AND SKIN ABRASION OR SRATCHES FROM THE METAL PARTS OF BRACES OR WIRES.

Allergic reactions to dental material are rare, but do occur. Abrasions or scratches from the braces or wires can occur, which are usually not serious. Minor irritations are common at first. Most of these are very manageable by the patient or with an adjustment by the orthodontist. However, all precautions must be taken to avoid broken and dismounted braces, as well as, the more serious problems related to braces that fit outside the mouth. For example, a serious injury could result from a headgear appliance being pulled out of the mouth while it is still attached around the head.

INJURIES DURING ACTUAL TREATMENT PROCEDURES.

The patient could inadvertently be scratched or poked by instruments used in the mouth, especially if the patient moves at a critical time during the procedure. Swallowing part of the brace, chipping a tooth, or dislodging a restoration are unusual occurrences but can happen.

TEMPORO-MANDIBULAR JOINT DISORDERS – TMJ AND/OR CLICKING.

Symptoms may develop, or a pre-existing condition may worsen during orthodontic treatment or at any time during one's life. Tooth position or bite can be a factor. However, TMJ problems are not at all bite related. If a disorder occurs, it may be necessary to consult a TMJ specialist.

GROWTH PATTERNS – JAW GROWTH OCCURING DURING AND AFTER ORTHODONTIC TREATMENT.

Occasionally, a person's normal jaw growth becomes uneven. As a result, the upper and lower jaws may not relate properly to each other and to the rest of the face. Skeletal growth disharmony is a biological process beyond the orthodontist's control and is not always predictable. This change may require additional orthodontic treatment sometimes in conjunction with oral surgery.

ORTHOGNATHIC OR ORTHODONTIC SURGERY – JAW SURGERY TO ESTABLISH PROPER JAW / FACE RELATIONSHIPS.

Patients requiring this procedure will need pre-surgical and post-surgical orthodontics. The surgical procedure is an operation performed in the hospital by an oral surgeon. All aspects of this procedure would be discussed in detail prior to any treatment.

RELAPSE – SHIFTING OF TEETH FOLLOWING TREATMENT.

Some minor shifting of teeth following treatment will probably occur. The lower front teeth are the most common teeth to shift. Relapse can be minimized if retainers are worn indefinitely as prescribed.

DENTAL CHECK-UPS.

All necessary dental work must be completed prior to starting orthodontic treatment. It is important that the patient maintain regular dental exams during orthodontic treatment as prescribed by his or her dentist.

Our intent is to inform you of some of the many potential problems that exist. There may be other inherent risks not mentioned. Every effort will be made to avoid any possible complications. By proper understanding and good cooperation, you can help us avoid any problems. Additional detailed information or explanation is available from Dr. Hardy.

Please sign this sheet after you have read and understood the above and consent to treatment.

_____ _____

Signature **Date**

Notice of Privacy Practices

This notice describes how health information about your child may be used and disclosed and how you can get access to this information. Please read it carefully. The privacy of your child's health information is important to us.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your child's health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your child's health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect July 1, 2009, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a signifi cant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Uses And Disclosures Of Health Information

We use and disclose health information about you and your child for treatment, payment, and healthcare operations. For example: Treatment: We may use or disclose your child's health information to a physician or other healthcare provider providing treatment to your child. Payment: We may use and disclose your child's healthcare information to obtain payment for services we provide. Healthcare Operations: We may use and disclose your child's health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, training programs, accreditation, certifi cation, licensing or credentialing activities. Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your child's health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Unless you give us a written authorization, we cannot use or disclose your child's health information for any reason except those described in this Notice. To Your Family and Friends: We must disclose your child's health information to you, as described in the Patient Rights section of this Notice. We may disclose your child's health information to a family member, friend or other person to the extent necessary to help with your child's healthcare or with payment for your child's healthcare, but only if you agree that we may do so. Persons Involved in Care: We may use or disclose health information to notify, or assist in the notifi cation (including identifying or locating) of a family member, your child's personal representative or another person responsible for your child's care, of your child's location and/ or general condition. If you are present, then prior to use or disclosure of your child's health information, we will provide you with an opportunity to object to such uses or disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your child's healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your child's best interest in allow a person to pick up fi lled prescriptions, medical supplies, x-rays, or other similar forms of health information. Marketing Health-Related Services: We will not use your child's health information for marketing communications without your written authorization. Required by Law: We may use or disclose your child's health information when we are required to do so by law. Abuse or Neglect: We may disclose your child's health information to appropriate authorities if we reasonably believe that your child is a victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your child's health information to the extent necessary to avert a serious threat to your child's health or safety or the health or safety of others.

Appointment Reminders

We may use or disclose your child's information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Patient Rights

Access: You have the right to look at or get copies of your child's health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your child's health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. If you request copies, we will charge you a reasonable fee for each page, a reasonable rate per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your child's health information in that format. Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your child's health information for purposes other than treatment, payment and healthcare operations. Alternative Communication: You have the right to request that we communicate with you about your child's health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or locations, and provide satisfactory explanation how payments will be handled under the alternative means or location you request. Amendment: You have the right to request that we amend your child's health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. Electronic Notice: If you receive this Notice on our web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your or your child's privacy rights, or you disagree with a decision we made about your access to your child's health information or in response to a request you made to amend or restrict the use or disclosure of your child's health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed on this Notice. We support your right to privacy of your child's health information.

_____ _____

Signature **Date**

My signature indicates that I have reviewed a copy of this office's Notice of Privacy Practices.