

Patient

Today's date: _____ Name: _____
Date of birth: _____ Sex: Male or Female
Address: _____ City: _____ State: _____ Zip: _____
Patient Phone #: _____ (used to provide Instructional videos)
Email address: _____

Billing Party(RESPONSABLE PERSON)

Mother's name: _____ Date of birth: _____
Email address: _____ Mobile #: _____
Address if different from patient: _____

Father's name: _____ Date of birth: _____
Email address: _____ Mobile #: _____
Address if different from patient: _____

Private insurance

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

List name/s of person/s who will be bringing patient to his/her appointments

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.

AUXILIARY 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 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-VITAL OR 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 these problems.

TEMPROMANDIBULAR JOINTS (TMJ) In some instances 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 recommended in these cases.

POST-TREATMENT TOOTH 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 central 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 by the responsible party.

Alan A. Curtis DDS, MS/ Paul Robinson DMD/ R. Thomas Tipton DMD, MSD/ Jason Judd DDS
ORTHODONTISTS

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: _____

Social Media and Publications Consent

\$99Braces/ Horizon Orthodontics/ Smiles4Less Orthodontics

I authorize \$99Braces/Horizon Orthodontics/Smiles 4 Less Orthodontics to use photographs, and/or video of myself/child for Social Media, marketing promotions, flyers and posters.

“Social Media Sites” means any form of social network in the internet, including, without limitation, \$99Braces/Horizon Orthodontics/Smiles 4 Less Orthodontics website, Facebook, Instagram and Twitter.

Print name of Parent/Guardian or Self: _____

Date: _____

Signature of Parent/Guardian: _____

Date: _____

Print name of Youth/Child: _____

Date: _____

24 Hour Cancellation & “No Show” Fee Policy

Effective January 2019

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, \$99 Braces/ Horizon Orthodontics/Smiles 4 Less Orthodontics reserves the right to charge a fee of \$20.00 for all missed appointments (“No shows”) and appointments which are not cancelled within a 24-hour advance notice.

“No Show” fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple “no shows” in any 12 month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

Patient Name

Date

Signature

Patient's Dental History

Patient Name: _____

Dentist Name: _____ When was the last exam and cleaning? _____

	Yes	No
Do your gums bleed when you brush?		
Have you ever been told that you have Periodontal Disease?		
Are you currently seeing a Periodontist for your cleanings?		
Do you have any clicking, popping or pain in the jaw point?		
Do you clench or grind your teeth?		
Do you have any problems opening or closing your mouth?		
Are your wisdom teeth still present?		
Are you interested in whitening your teeth?		
Are you interested in Invisalign?		
Is there dental work that is in progress or needs to be completed?		
Have you ever injured or had trauma to your teeth, face or jaw?		
If yes, please explain:		
Have you ever had prior orthodontic treatment in the past?		
If yes, please explain:		
Have you been advised by your physician to take an antibiotic prior to dental treatment?		
If yes, please explain:		
Would you like to see facial appearance to change with orthodontics?		
If yes, please explain:		

Physician's Name: _____

Patient's Medical History

	Yes	No
Do you have health problems, disorders or conditions?		
If yes, please explain:		
Are you allergic to any medications?		
If yes, please explain:		
Allergic to LATEX?		
Are there any facial features that you would like to see after completing orthodontic treatment?		
If yes, please explain:		
Are you pregnant?		

Patient's Health History

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