Welcome To Our Practice

CHERYL W. ALDRIDGE DMD, MS

Please take a few minutes to answer the following questions so we can better assist you with your dental care needs.

How Did You Hear About Us? ☐ Dentist ☐ Family/Friend Name_____ ☐ TV Channel _____
☐ Yellow Pages ☐ Online Search _____ ☐ Other_____

PLEASE PRINT USING BLACK OR BLUE INK

Today's Date _____ Birth Date _____ Patient Social Security # _____

Patient Name _____
(Last Name) (First Name) (Middle Initial)

Street Address _____

City _____ State _____ Zip _____

Occupation / ☐ Full Time Student _____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Patient Phone_____ ☐ Home ☐ Cell Patient Work Phone _____

Employer _____ Employer Phone _____

Employer Address _____

Person responsible for this account (Cannot be a minor)_____Relationship _____

Responsible person's Social Security #_____ Phone _____ ☐ Home ☐ Cell

In case of emergency contact (NOT LIVING WITH PATIENT):

Name _____ Relationship _____

Emergency Phone _____ ☐ Home ☐ Cell Emergency Work Phone_____

PRIMARY INSURANCE

Insured Name _____
(Last Name) (First Name) (Middle Initial)

Insured Relationship to Patient _____ Insured Birth Date _____

Insured Social Security # _____Phone _____ ☐ Home ☐ Cell

Insured Party Employed By _____

Occupation _____Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

ADDITIONAL INSURANCE

Additional Insured Name _____
(Last Name) (First Name) (Middle Initial)

Insured Relationship to Patient _____ Insured Birth Date _____

Insured Social Security # _____Phone _____ ☐ Home ☐ Cell

Insured Party Employed By _____

Occupation _____Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

ASSIGNMENT AND RELEASE

I authorize my insurance company to pay to Greater Chattanooga Orthodontics all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize Greater Chattanooga Orthodontics to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. **Payment is due in full at time of treatment unless prior arrangements have been approved.**

Signature _____ Date _____

Patient Information

PLEASE FILL OUT IF PATIENT IS A MINOR

Name of Person(s) Accompanying Minor Today _____

Relationship _____

Do you have legal custody of this child? ☐ Yes ☐ No

List Brothers/Sisters With Age:_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐Separated

Mother's Name _____ Mother's Address _____
Mother's SS# _____ Phone _____ ☐ Home ☐ Cell
Employer's Name_____Work Phone #_____
Office Address _____ How Long? _____

Father's Name _____ Father's Address _____
Father's SS# _____ Phone _____ ☐ Home ☐ Cell
Employer's Name_____Work Phone #_____
Office Address _____ How Long? _____

OTHER CONTACTS

Please list any other person(s) allowed to receive medical information about the patient other than the Parent/Guardian for a minor child:

Name _____Relationship _____
Name _____Relationship _____
Name _____Relationship _____

ALLERGIES

Please list any allergies that would affect the patient's treatment. This might include allergies to specific drugs, latex, etc. You may also return to this page to list any other special conditions that were not addressed on the general information sheet or personal medical history affecting patient treatment.

Patient Name_____

Allergies or other conditions:

_____

_____

_____

_____

_____

_____

Personal Medical History

MEDICATIONS

Please list any medications the patient is currently taking:

_____

_____

_____

MEDICAL HISTORY (PLEASE FILL OUT FOR CHILDREN AND ADULT PATIENTS)

Has the patient had any of the following?

- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Bones / Joints
- ☐ Artificial Valves
- ☐ Asthma / Difficulty Breathing
- ☐ Blood Transfusion
- ☐ Cancer / Chemotherapy
- ☐ Congenital Heart Defects
- ☐ Diabetes
- ☐ Drug / Alcohol Abuse
- ☐ Emphysema
- ☐ Epilepsy / Seizures / Fainting
- ☐ Fever Blisters / Herpes
- ☐ Glaucoma
- ☐ Heart Attack / Stroke
- ☐ Heart Murmur
- ☐ Heart Surgery / Pacemaker
- ☐ Hemophilia / Abnormal Bleeding
- ☐ Hepatitis
- ☐ High / Low Blood Pressure
- ☐ HIV +/ AIDS
- ☐ Hospitalized For Any Reason
- ☐ Kidney Problems
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Psychiatric Problems
- ☐ Rheumatic / Scarlet Fever
- ☐ Severe / Frequent Headaches
- ☐ Shingles
- ☐ Sinus Problems
- ☐ Tuberculosis
- ☐ Ulcers / Colitis

Medical Questions

Is the patient currently under the care of a physician? ☐ Yes ☐ No

If Yes, Reason_____

Have the patient's adenoids or tonsils been removed? ☐ Yes ☐ No

If Yes, When_____

Patient's current general health is: ☐ Good ☐ Fair ☐ Poor

Is the patient currently pregnant? ☐ Yes ☐ No

Does / did the patient have any of the following habits?

☐ Lip Sucking / Biting ☐ Mouth Breathing ☐ Nail Biting

☐ Speech Problems ☐ Thumb / Finger Sucking ☐ Tongue Thrust

☐ None

Dental Questions

General Dentist _____City _____

State_____Phone_____

Ever experienced pain / discomfort in the jaw area (TMJ)? ☐ Yes ☐ No

Does patient grind his/her teeth? ☐ Yes ☐ No

Have there been injuries to the mouth, face, or jaw? ☐ Yes ☐ No

If yes, please explain: _____

_____

Does the patient brush his/her teeth daily? ☐ Yes ☐ No | Floss? ☐ Yes ☐ No

Does the patient have missing or extra permanent teeth? ☐ Yes ☐ No

Patient's current dental health is: ☐ Good ☐ Fair ☐ Poor

CHECK DEGREE OF HABITS BELOW. ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL.

	HEAVY	CASUAL	LIGHT	NONE
Alcohol	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐
Coffee	☐	☐	☐	☐

	HEAVY	CASUAL	LIGHT	NONE
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Sleep	☐	☐	☐	☐

	HEAVY	CASUAL	LIGHT	NONE
Soft Drinks	☐	☐	☐	☐
Sugar/Sugar Products	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Water	☐	☐	☐	☐

I certify that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictist confidence, and it is my responsibility to inform this office of any changes in my/my child's medical status. I will not hold Greater Chattanooga Orthodontics or any member of its staff responsible for any errors or omissions that I may have made in the completion of this form.

I authorize the dental staff to perform any necessary dental services that I/my child may need during diagnosis and treatment with my informed consent.

Signature_____ Date _____

Map and Directions

Our office is located in Chattanooga, Tennessee. We are located on Gunbarrel Road directly across from Panera Bread and the Target Shopping Center.

Our address is 1829 Gunbarrel Road, Suite A-1, Chattanooga TN 37421

From Chattanooga - Starting Downtown on I-24

From I-24 East, Merge onto 1-75 North

Take Exit 3A to merge onto East Brainerd Road

Turn left at Gunbarrel Road

Office will be 3/4 mile on left with green roof.

From Dalton, Georgia

Take 1-75 toward Knoxville at 1-75 & 1-24 Split

Take Exit 3A to merge onto East Brainerd Road

Turn left at Gunbarrel Road

Office will be 3/4 mile on left with green roof.

GREATER CHATTANOOGA ORTHODONTICS

NOTICE OF PRIVACY PRACTICES

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

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect **04 / 01 / 13**, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more in formation about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply**. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment** or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your 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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (email).

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 privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your 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 at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: Katie Holt

Telephone: 423.296.0407 Fax: 423.296.0174

Address: 1829 Gunbarrel Road, Suite A, Chattanooga, TN 37421

Email: manager@chattortho.com

GREATER CHATTANOOGA ORTHODONTICS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Note: You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

[ ] Individual refused to sign

[ ] Communications barriers prohibited obtaining the acknowledgement

[ ] An emergency situation prevented us from obtaining acknowledgement

[ ] Other (Please Specify)

_____
_____
_____
_____
_____
_____
_____

GREATER CHATTANOOGA ORTHODONTICS

At Greater Chattanooga Orthodontics, we care about your health and the health of all of our patients. In order to make your experience in orthodontic care the best it can be please note the two policies below. We have adopted these policies to contribute to and ensure the safe and efficient operation of our office as we serve you, our patient.

ON-TIME POLICY FOR PATIENTS

Thank you for allowing us to serve your orthodontic needs. We are glad to have you as a patient and want to make your experience as pleasant as possible. We will take every measure possible to ensure that you are seen at your scheduled appointment time.

Your scheduled appointment time has been reserved specifically for you. We request at least a 24-hour notice if you need to cancel your appointment. We are aware that unforeseen events sometimes require missing an appointment and appreciate your cooperation.

In order to maintain our running on time policy, we ask that patients be on time or a few minutes early. We understand that due to traffic and other life demands that you may be delayed and, consequently, late for a scheduled appointment. We ask that if you are running more than five minutes late to contact our office so that we are better able to accomodate your needs.

If you are more than 15 minutes late, we will have to reschedule your appointment so as not to adversely affect other patients and their appointment times. We will be happy to schedule you for the same day if there is a time slot available. If not, we will give you the next available appointment on another day. We will not be able to make any exceptions to this policy.

The intent of this on-time policy is to promote an effecient operation on our part and, as a result, a more pleasant and predictable experience for you. We value your time and appreciate your consideration of our time and that of other patients.

PATIENT RESPONSIBILITY POLICY

Patients and their guardians must understand the commitment it will take to ensure that the proposed orthodontic treatment is completed successfully and in a timely fashion. This includes the avoidance of hard, crunchy and sticky foods; keeping all regularly scheduled appointments; following the doctor's directions; and performing the necessary daily brushing and flossing.

Braces require constant adjustment and care in order to work. Generally, one can plan on visiting the orthodontist every four to eight weeks. The doctor will determine when the next appointment can and should be made. Broken or neglected braces can cause serious damage to teeth and gums. Therefore, the doctor reserves the right to remove the braces and stop treatment if the patient fails to maintain proper hygiene or repeatedly fails to keep scheduled appointments.

I understand the commitment it will take on the part of myself as well as the patient to ensure that the proposed orthodontic treatment is completed successfully. If my child is a minor, I have addressed his/her responsibility to avoid hard, crunchy and sticky foods, keep all regularly scheduled appointments, follow all directions of the doctor, and perform the necessary daily brushing and flossing. I understand that the orthodontist may stop treatment and remove my child's braces if there are two consecutive or a total of three missed appointments; excessive loss or damage to the braces; inability to brush or floss the teeth daily; and/or failure to cooperate with the wearing of all appliance attachments.

_____ _____

Signature of Parent or Guardian Today's Date

INFORMED CONSENT

for the Orthodontic Patient

Risks and Limitations of Orthodontic Treatment

GREATER CHATTANOOGA ORTHODONTICS

Successful orthodontic treatment is a partnership between the orthodontist and the patient. The doctor and staff are dedicated to achieving the best possible result for each patient. As a general rule, informed and cooperative patients can achieve positive orthodontic results. While recognizing the benefits of a beautiful healthy smile, you should also be aware that, as with all healing arts, orthodontic treatment has limitations and potential risks. These are seldom serious enough to indicate that you should not have treatment; however, all patients should seriously consider the option of no orthodontic treatment at all by accepting their present oral condition. Alternatives to orthodontic treatment vary with the individual's specific problem, and prosthetic solutions or limited orthodontic treatment may be considerations. You are encouraged to discuss alternatives with the doctor prior to beginning treatment.

Orthodontics and Dentofacial Orthopedics is the dental specialty that includes the diagnosis, prevention, interception and correction of malocclusion, as well as neuromuscular and skeletal abnormalities of the developing or mature orofacial structures.

An orthodontist is a dental specialist who has completed at least two additional years of graduate training in orthodontics at an accredited program after graduation from dental school.

American Association of **Orthodontists**

Results of Treatment
Orthodontic treatment usually proceeds as planned, and we intend to do everything possible to achieve the best results for every patient. However, we cannot guarantee that you will be completely satisfied with your results, nor can all complications or consequences be anticipated. The success of treatment depends on your cooperation in keeping appointments, maintaining good oral hygiene, avoiding loose or broken appliances, and following the orthodontist's instructions carefully.

Length of Treatment
The length of treatment depends on a number of issues, including the severity of the problem, the patient's growth and the level of patient cooperation. The actual treatment time is usually close to the estimated treatment time, but treatment may be lengthened if, for example, unanticipated growth occurs, if there are habits affecting the dentofacial structures, if periodontal or other dental problems occur, or if patient cooperation is not adequate. Therefore, changes in the original treatment plan may become necessary. If treatment time is extended beyond the original estimate, additional fees may be assessed.

Discomfort
The mouth is very sensitive so you can expect an adjustment period and some discomfort due to the introduction of orthodontic appliances. Non-prescription pain medication can be used during this adjustment period.

Relapse
Completed orthodontic treatment does not guarantee perfectly straight teeth for the rest of your life. Retainers will be required to keep your teeth in their new positions as a result of your orthodontic treatment. You must wear your retainers as instructed or teeth may shift, in addition to other adverse effects. Regular retainer wear is often necessary for several years following orthodontic treatment. However, changes after that time can occur due to natural causes, including habits such as tongue thrusting, mouth breathing, and growth and maturation that continue throughout life. Later in life, most people will see their teeth shift. Minor irregularities, particularly in the lower front teeth, may have to be accepted. Some changes may require additional orthodontic treatment or, in some cases, surgery. Some situations may require non-removable retainers or other dental appliances made by your family dentist.

Extractions
Some cases will require the removal of deciduous (baby) teeth or permanent teeth. There are additional risks associated with the removal of teeth which you should discuss with your family dentist or oral surgeon prior to the procedure.

Orthognathic Surgery
Some patients have significant skeletal disharmonies which require orthodontic treatment in conjunction with orthognathic (dentofacial) surgery. There are additional risks associated with this surgery which you should discuss with your oral and/or maxillofacial surgeon prior to beginning orthodontic treatment. Please be aware that orthodontic treatment prior to orthognathic surgery often only aligns the teeth within the individual dental arches. Therefore, patients discontinuing orthodontic treatment without completing the planned surgical procedures may have a malocclusion that is worse than when they began treatment!

Decalcification and Dental Caries
Excellent oral hygiene is essential during orthodontic treatment as are regular visits to your family dentist. Inadequate or improper hygiene could result in cavities, discolored teeth, periodontal disease and/or decalcification. These same problems can occur without orthodontic treatment, but the risk is greater to an individual wearing braces or other appliances. These problems may be aggravated if the patient has not had the benefit of fluoridated water or its substitute, or if the patient consumes sweetened beverages or foods.

Root Resorption
The roots of some patients' teeth become shorter (resorption) during orthodontic treatment. It is not known exactly what causes root resorption, nor is it possible to predict which patients will experience it. However, many patients have retained teeth throughout life with severely shortened roots. If resorption is detected during orthodontic treatment, your orthodontist may recommend a pause in treatment or the removal of the appliances prior to the completion of orthodontic treatment.

Nerve Damage
A tooth that has been traumatized by an accident or deep decay may have experienced damage to the nerve of the tooth. Orthodontic tooth movement may, in some cases, aggravate this condition. In some cases, root canal treatment may be necessary. In severe cases, the tooth or teeth may be lost.

Periodontal Disease
Periodontal (gum and bone) disease can develop or worsen during orthodontic treatment due to many factors, but most often due to the lack of adequate oral hygiene. You must have your general dentist, or if indicated, a periodontist monitor your periodontal health during orthodontic treatment every three to six months. If periodontal problems cannot be controlled, orthodontic treatment may have to be discontinued prior to completion.

Injury From Orthodontic Appliances
Activities or foods which could damage, loosen or dislodge orthodontic appliances need to be avoided. Loosened or damaged orthodontic appliances can be inhaled or swallowed or could cause other damage to the patient. You should inform your orthodontist of any unusual symptoms or of any loose or broken appliances as soon as they are noticed. Damage to the enamel of a tooth or to a restoration (crown, bonding, veneer, etc.) is possible when orthodontic appliances are removed. This problem may be more likely when esthetic (clear or tooth colored) appliances have been selected. If damage to a tooth or restoration occurs, restoration of the involved tooth/teeth by your dentist may be necessary.

Headgears
Orthodontic headgears can cause injury to the patient. Injuries can include damage to the face or eyes. In the event of injury or especially an eye injury, however minor, immediate medical help should be sought. Refrain from wearing headgear in situations where there may be a chance that it could be dislodged or pulled off. Sports activities and games should be avoided when wearing orthodontic headgear.

Temporomandibular (Jaw) Joint Dysfunction
Problems may occur in the jaw joints, i.e., temporomandibular joints (TMJ), causing pain, headaches or ear problems. Many factors can affect the health of the jaw joints, including past trauma (blows to the head or face), arthritis, hereditary tendency to jaw joint problems, excessive tooth grinding or clenching, poorly balanced bite, and many medical conditions. Jaw joint problems may occur with or without orthodontic treatment. Any jaw joint symptoms, including pain, jaw popping or difficulty opening or closing, should be promptly reported to the orthodontist. Treatment by other medical or dental specialists may be necessary.

Impacted, Ankylosed, Unerupted Teeth
Teeth may become impacted (trapped below the bone or gums), ankylosed (fused to the bone) or just fail to erupt. Oftentimes, these conditions occur for no apparent reason and generally cannot be anticipated. Treatment of these conditions depends on the particular circumstance and the overall importance of the involved tooth, and may require extraction, surgical exposure, surgical transplantation or prosthetic replacement.

Occlusal Adjustment
You can expect minimal imperfections in the way your teeth meet following the end of treatment. An occlusal equilibration procedure may be necessary, which is a grinding method used to fine-tune the occlusion. It may also be necessary to remove a small amount of enamel in between the teeth, thereby "flattening" surfaces in order to reduce the possibility of a relapse.

Non-Ideal Results
Due to the wide variation in the size and shape of the teeth, missing teeth, etc., achievement of an ideal result (for example, complete closure of a space) may not be possible. Restorative dental treatment, such as esthetic bonding, crowns or bridges or periodontal therapy, may be indicated. You are encouraged to ask your orthodontist and family dentist about adjunctive care.

Third Molars
As third molars (wisdom teeth) develop, your teeth may change alignment. Your dentist and/or orthodontist should monitor them in order to determine when and if the third molars need to be removed.

Continued on next page

Patient or Parent/Guardian Initials _____ **X**

PLEASE FILL OUT ALL FIELDS DENOTED WITH A **X**

Patient **X** _____ Date _____

Allergies
Occasionally, patients can be allergic to some of the component materials of their orthodontic appliances. This may require a change in treatment plan or discontinuance of treatment prior to completion. Although very uncommon, medical management of dental material allergies may be necessary.

General Health Problems
General health problems such as bone, blood or endocrine disorders, and many prescription and non-prescription drugs (including bisphosphonates) can affect your orthodontic treatment. It is imperative that you inform your orthodontist of any changes in your general health status.

Use of Tobacco Products
Smoking or chewing tobacco has been shown to increase the risk of gum disease and interferes with healing after oral surgery. Tobacco users are also more prone to oral cancer, gum recession, and delayed tooth movement during orthodontic treatment. If you use tobacco, you must carefully consider the possibility of a compromised orthodontic result.

Temporary Anchorage Devices
Your treatment may include the use of a temporary anchorage device(s) (i.e. metal screw or plate attached to the bone.) There are specific risks associated with them.

It is possible that the screw(s) could become loose which would require its/their removal and possibly relocation or replacement with a larger screw. The screw and related material may be accidentally swallowed. If the device cannot be stabilized for an adequate length of time, an alternate treatment plan may be necessary.

It is possible that the tissue around the device could become inflamed or infected, or the soft tissue could grow over the device, which could also require its removal, surgical excision of the tissue and/or the use of antibiotics or antimicrobial rinses.

It is possible that the screws could break (i.e. upon insertion or removal.) If this occurs, the broken piece may be left in your mouth or may be surgically removed. This may require referral to another dental specialist.

When inserting the device(s), it is possible to damage the root of a tooth, a nerve, or to perforate the maxillary sinus. Usually these problems are not significant; however, additional dental or medical treatment may be necessary.

Local anesthetic may be used when these devices are inserted or removed, which also has risks. Please advise the doctor placing the device if you have had any difficulties with dental anesthetics in the past.

If any of the complications mentioned above do occur, a referral may be necessary to your family dentist or another dental or medical specialist for further treatment. Fees for these services are not included in the cost for orthodontic treatment.

Patient or Parent/Guardian Initials _____ **X**

ACKNOWLEDGEMENT

I hereby acknowledge that I have read and fully understand the treatment considerations and risks presented in this form. I also understand that there may be other problems that occur less frequently than those presented, and that actual results may differ from the anticipated results. I also acknowledge that I have discussed this form with the undersigned orthodontist(s) and have been given the opportunity to ask any questions. I have been asked to make a choice about my treatment. I hereby consent to the treatment proposed and authorize the orthodontist(s) indicated below to provide the treatment. I also authorize the orthodontist(s) to provide my health care information to my other health care providers. I understand that my treatment fee covers only treatment provided by the orthodontist(s), and that treatment provided by other dental or medical professionals is not included in the fee for my orthodontic treatment.

X _____
Signature of Patient/Parent/Guardian Date

_____
Signature of Orthodontist/Group Name Date

_____
Witness Date

CONSENT TO UNDERGO ORTHODONTIC TREATMENT

I hereby consent to the making of diagnostic records, including x-rays, before, during and following orthodontic treatment, and to the above doctor(s) and, where appropriate, staff providing orthodontic treatment prescribed by the above doctor(s) for the above individual. I fully understand all of the risks associated with the treatment.

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I hereby authorize the above doctor(s) to provide other health care providers with information regarding the above individual's orthodontic care as deemed appropriate. I understand that once released, the above doctor(s) and staff has(have) no responsibility for any further release by the individual receiving this information.

CONSENT TO USE OF RECORDS

I hereby give my permission for the use of orthodontic records, including all photographs made in the process of examinations, treatment, and retention for purposes of professional consultations, research, marketing, advertising, education, or publication in professional journals.

X _____
Signature Date

_____
Witness Date

I have the legal authority to sign this on behalf of

X _____
Name of Patient

X _____
Relationship to Patient

Notes