brian smith
ORTHODONTICS

PATIENT INFORMATION

Patient's Name _____ Date _____

Date of Birth _____Social Security # _____Work/Cell_____

Address_____City_____State_____Zip_____

Email _____Home Phone_____ Sex_____
(For in-house use only)

Who may we thank for referring you? _____

RESPONSIBLE PARTY INFORMATION

Guarantor Name _____ Marital Status _____

Date of Birth _____ Sex _____ Social Security #_____

Address _____City _____ Zip _____

Phone _____Email _____
(For in-house use only)

Employer _____ Occupation _____

Employer Address _____City_____State_____Zip_____

EMERGENCY INFORMATION

Name_____ Relation_____ Phone_____
Address_____Alternate Phone_____

DIPLOMATE, AMERICAN BOARD OF ORTHODONTICS

PATIENT MEDICAL HISTORY:

Have you been under the care of a physician in the last two years?:

Physician's Name _____ Reason for Care _____
Have you ever had any operations? _____
Have you ever been hospitalized? _____
Have you ever had or do you now have any of the following: Y - Yes, N - No

__AIDS/HIV	__Diabetes	__Latex allergy
__Allergies	__Endocrine Problems	__Nervous Disorder
__Anemia	__Epilepsy	__Prolonged Bleeding
__Asthma	__Fainting/Dizziness	__Rheumatic
__Birth Defects	__Heart Problems	__Tuberculosis
__Bone Disorder	__Hepatitis	__Other_____
__Cancer	__Liver Problems	_____

List any medications you are currently taking. _____

PATIENT DENTAL HISTORY:

Current Dentist_____ Date of last exam _____
How long since last teeth cleaning? _____ How often do you brush? ___ floss? ___

Do you have any of the following:

___Family members who have had Orthodontics	___Hot/cold sensitivity
___Injuries to face, jaw, mouth or teeth	___Bleeding gums/bad taste
___Root canals, crowns or bridge	___Suck thumb/fingers
___Clicking, popping, grinding or pain in jaw	___Missing or extra teeth
___Difficulty chewing	___Difficulty breathing

Have you ever had an Orthodontic consultation or treatment before? _____

What was the outcome of your consultation or treatment?_____
_____

What do you hope to achieve with Orthodontic treatment? _____
_____

I understand that where appropriate, credit bureau reports may be obtained. I also understand that there are certain limitations and risks with any treatment and that while most patients achieve their desired results, it is not a guarantee.

_____ _____
Patient Signature Date

_____ _____
Guarantor (if patient is under 18) Date

CONSENT FOR ORTHODONTIC TREATMENT

In the vast majority of orthodontic cases, significant improvements can be achieved. While the benefits of a pleasing smile and healthy teeth are widely appreciated, orthodontic treatment remains an elective procedure. Like any other treatment to the body, it has some inherent risks and limitations. These seldom prevent treatment, but should be considered in making the decision to undergo treatment.

LACK OF PATIENT COOPERATION OR COMPLIANCE. (Most common cause for excessive treatment time). Lack of, or undesirable growth, insufficient wearing of elastics or headgear, broken appliances, and missed appointments are important factors, which can lengthen time and adversely affect the quality of treatment results.

HEADGEAR WEAR. Instructions must be followed carefully. Injury could occur if the headgear is pulled out while the elastic force is attached.

NON VITAL OR DEAD TOOTH. (Tooth traumatized by blow or other causes). A traumatized tooth can die over a long period of time with or without orthodontic treatment. This tooth may flare up during orthodontic movement and require endodontic treatment (root canal).

IMPACTED TEETH. (Teeth unable to erupt normally). In attempting to move impacted teeth, especially cuspids (canine teeth), various problems are sometimes encountered which may lead to loss of the tooth or periodontal problems.

ROOT RESORPTION. (Shortening of root ends). This can occur with or without orthodontic treatment. Under healthy conditions, the shortened roots are usually no problem. Trauma, cuts, impaction, endocrine disorders, and idiopathic reasons can also cause problems.

TEMPOROMANDIBULAR JOINTS - TMJ. (Sliding hinge connecting the upper and lower jaws). Possible problems may exist or occur during orthodontic treatment. Tooth position and bite can be a factor in this condition. An equilibration by your doctor may be recommended after your appliances are removed to improve occlusal relationship.

GROWTH PATTERNS. (Facial growth during or after treatment). Bad habits, unusual skeletal patterns and insufficient or undesirable growth can compromise the dental results, effect a facial change, and cause shifting of teeth during retention.

POST TREATMENT TEETH MOVEMENT. (Relapse). There is a likelihood that teeth will shift or settle after treatment as well as after retention. Some changes may be desirable, but others will not. Rotations and crowding of the lower anterior teeth are the most common examples. Slight spaces in the extraction site or between the upper centrals are other examples.

UNUSUAL OCCURRENCES: Swallowing appliances, chipping teeth, and dislodging restoration.

After reading the above:

I consent to the taking of photographs and X-rays before, during and after treatment. I certify that I have read the contents of this form, realize the risks and limitations involved, and do consent to orthodontic treatment.

_____ _____

Signature Date

_____ _____

Guarantor Signature (if patient is under 18 years of age) Date

I hereby give permission to Dr. Brian Smith Orthodontics to use photos of _____'s smile for the sole purpose of practice enhancement.

_____

Patient Signature

_____ _____

Guarantor Signature (if patient is under 18 years of age) Date

Insurance Benefits Summary

At this time, as a courtesy to our patients, our office will file your insurance. Prior to your initial appointment you will need to call your insurance company to obtain your quoted orthodontic benefits with the following information:

Lifetime maximum $_____
Annual maximum (if any) $_____
Percentage of payout _____%
Benefits remaining $_____
Age limitations _____
Any exclusions (waiting period) _____

Insurance Information

Insurance Subscriber_____ Date of Birth_____
Insured's Name _____Subscriber Social Security #_____
Insured's Employer_____ Occupation_____
Insurance Co. Name _____Effective Date_____
Insurance Co. Address_____City_____State_____Zip_____
Group #_____ Policy #_____ Phone #_____

Secondary Insurance Information**

Insurance Subscriber_____ Date of Birth_____
Insured's Name _____ Subscriber Social Security #_____
Insured's Employer_____ Occupation_____
Insurance Co. Name _____ Effective Date_____
Insurance Co. Address_____City_____State_____Zip_____
Group #_____ Policy #_____ Phone #_____

An additional charge of $25.00 will be applied for filing to **each additional insurance company.

Thank you for providing this information for us so that we can be efficient in caring for your insurance benefits.

We appreciate you considering Dr. Brian Smith Orthodontics for your or your child's precious smile. We will do our best to honestly maximize your orthodontic benefits.

Dr. Brian Smith Orthodontics
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