

FOR ADULTS: WELCOME TO OUR PRACTICE

1.) ABOUT YOU

Today's Date: _____ DOB: _____
Name: _____ AGE: _____
Last First Mi (Mr. Mrs. Ms.)
I prefer to be called: _____
Home #: _____
Work #: _____
SS#: _____
DL#: _____
Home Address:

Apt# _____
City State Zip

2.) ABOUT YOUR EMPLOYER:

Name: _____
Address: _____
How long have you worked there? _____
Occupation: _____
When & Where are the best times to reach you?

Other family members seen by us:

Who may we THANK for referring you? _____

3.) SPOUSE INFORMATION:

Name: _____
Employer: _____
WK#: _____
DL#: _____
SS#: _____
DOB: _____

DENTAL INFORMATION

Previous/Present Dentist: _____
Street: _____
Phone: _____
Last Visit: _____

5.) PRIMARY DENTAL INSURANCE:

Ins. Name: _____
Ins. Address: _____
Insurance Co. Phone #: _____
Group/Policy #: _____
Insured's Name: _____
Relationship to Patient: _____
Insured's DOB: _____
Insured's Employer: _____
SS#: _____
Orthodontic Coverage: YES NO

4.) RESPONSIBLE PARTY INFO:

Name: _____
Billing address: _____
City State Zip
WK#: _____ Ext. _____ HM#: _____
Cell #: _____
Email: _____
Employer: _____
DL#: _____
SS#: _____

Emergency Contact:

Name: _____ Relation: _____
WK#: _____ Ext. _____ HM#: _____

SECONDARY DENTAL INSURANCE

Ins. Name: _____
Ins. Address: _____
Insurance Co. Phone #: _____
Group/Policy #: _____
Insured's Name: _____
Relationship to Patient: _____
Insured's DOB: _____
Insured's Employer: _____
SS#: _____
Orthodontic Coverage: YES NO

6.) DENTAL HISTORY

Why have you come to the orthodontist today? _____

Are you currently in pain? Y N

Your current dental health is: Good Fair Poor

Have you ever had a serious/difficult problem associated with previous dental work? Y N

Have you ever had any pain or Tenderness in the jaw joint (TMJ/TMD)? Y N

Do you like your smile? Y N

Do your gums ever bleed? Y N

How many times a week do you floss?

How many times a day do you brush?

Types of bristles? Hard Medium Soft

7.) MEDICAL HISTORY

Do you have a personal physician? Y N

Name: _____

Phone: _____ Last visit: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a doctor?

Y N Explain: _____

Are you taking any prescription drugs? Y N

FOR WOMEN ONLY:

Are you taking birth control pills? Y N

Are you pregnant? Y N Week #: _____

Are you nursing? Y N

9.) I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental staff to perform the necessary dental services that I may need during treatment.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

OFFICE USE ONLY --- OFFICE USE ONLY --- OFFICE USE ONLY

I verbally reviewed the medical / dental Information above with the parent/guardian & Patient name herein.
Initials: _____ Date: _____
Doctor's comments: _____

8.) Have you ever had any of the following diseases or medical problems?

- | | | | |
|---|----------------|---|--------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N | Prosthesis | <input type="checkbox"/> Y <input type="checkbox"/> N | History of Scarlet Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Heart attack | <input type="checkbox"/> Y <input type="checkbox"/> N | Congenital Heart Def. |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N | Convulsions/Epilepsy |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N | Abnormal Bleeding |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Rheum. Fev. | <input type="checkbox"/> Y <input type="checkbox"/> N | Artificial Valves |
| <input type="checkbox"/> Y <input type="checkbox"/> N | HIV+/AIDS | <input type="checkbox"/> Y <input type="checkbox"/> N | Heart surgery/Pacmkr. |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Hemophilia | <input type="checkbox"/> Y <input type="checkbox"/> N | Any Stays in Hospital |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N | Kidney/Liver Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N | Mitral Valve Prolapse |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Tuberculosis | <input type="checkbox"/> Y <input type="checkbox"/> N | Artificial bones/joints |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Shingles | <input type="checkbox"/> Y <input type="checkbox"/> N | Sev./Freq. headaches |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Fever blister | <input type="checkbox"/> Y <input type="checkbox"/> N | Hi/Lo blood pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Venereal dis. | <input type="checkbox"/> Y <input type="checkbox"/> N | Drug/Alcohol Abuse |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Ulcers/Colitis | <input type="checkbox"/> Y <input type="checkbox"/> N | Blood Transfusion |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Heart Murm. | <input type="checkbox"/> Y <input type="checkbox"/> N | Anemia/Radiation tmt. |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Emphysema | <input type="checkbox"/> Y <input type="checkbox"/> N | Glaucoma |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Sinus Probs. | <input type="checkbox"/> Y <input type="checkbox"/> N | Difficulty Breathing? |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Other: _____ | | |

Are you allergic to any of the following?

- | | | | |
|---|--------------|---|--------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N | Aspirin | <input type="checkbox"/> Y <input type="checkbox"/> N | Erythromycin |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Codeine | <input type="checkbox"/> Y <input type="checkbox"/> N | Dental Anesthetics |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Latex | <input type="checkbox"/> Y <input type="checkbox"/> N | Tetracycline |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Penicillin | | |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Other: _____ | | |

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

Patient Name: _____ Date: _____

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 complication 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 _____

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.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect 4/1/03, 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 change. Before we make a significant 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 for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use or disclose your health information to obtain payment for services we provide you.

Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, 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 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. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect.

To Your Family, Friends and Persons Involved in Care: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare. We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

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 vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Court Orders and Subpoenas: We may disclose information in response to an appropriate court order or subpoena.

Law Enforcement: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent a serious threat your health and safety or the health and safety of the public or another person.

Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize 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 of protected health-related information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters). We may also contact you to provide information about treatment alternatives or other health-related information that may be of interest to you.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payment will be handled under the alternative means or location you request.

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.

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 privacy rights, or 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 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 the U.S. Department of Health and Human Services.

Contact Officer:..... OFFICE DIRECTOR

Telephone:..... (855) 272-2374

Email:..... shoocorp@fl4braces.com

Corporate Address:.... 3001 Executive Drive Suite 180 Clearwater, FL 33762

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: GIVING PATIENT CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Officer:..... OFFICE DIRECTOR

Telephone:..... (855) 272-2374

Email:..... shoocorp@fl4braces.com

Corporate Address:.... 3001 Executive Drive Suite 180 Clearwater, FL 33762

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of the Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you if you revoke this Consent.

SIGNATURE

I, _____, have had the full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

REVOCACTION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after that I have revoked my consent.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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)

