HARMONY
ORTHODONTICS

Patient Information Form

Patient Name: _____ Today's Date: _____

Preferred Name: _____ Gender: _____ Date of Birth: _____ Age: _____

Email: _____ Cell Phone: _____ Home Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

School: _____ Grade: _____

Who else have we treated in your family? _____

How did you hear about our office or who referred you? _____

Responsible Party: _____ Date of Birth: _____

Relationship to Patient: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced

Cell Phone: _____ Home Phone: _____ SSN: _____

Address: _____ City: _____ State: ___ Zip: _____

Employer: _____ Work Phone: _____ Email: _____

Spouse or Other Parent: _____ Date of Birth: _____

Relationship to Patient: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced

Cell Phone: _____ Home Phone: _____ SSN: _____

Address: _____ City: _____ State: ___ Zip: _____

Employer: _____ Work Phone: _____ Email: _____

Primary Dental Insurance

Name of Primary Person Covered by this Insurance: _____ SSN: _____

Insured's Mailing Address: _____ Date of Birth: _____

Insurance Company: _____ Insurance Phone #_____

Member ID#_____ Group #_____ Insured's Employer: _____

Secondary Dental Insurance (if applicable)

Name of Primary Person Covered by this Insurance: _____ SSN: _____

Insured's Mailing Address: _____ Date of Birth: _____

Insurance Company: _____ Insurance Phone #_____

Member ID#_____ Group #_____ Insured's Employer: _____

Consent to Exam

I understand that a pre-treatment exam and records are necessary before an orthodontist can make any specific treatment recommendations for my care. Pre-treatment records include a panoramic x-ray, facial and intra-oral digital photographs and a digital scan. I hereby consent to this complete orthodontic examination and to the taking of any necessary pretreatment records.

Name: _____ Signature: _____ Date: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Confidential Patient Health History

Medical History

Primary Physician: _____ Phone: _____ Approximate date of last dental cleaning: _____

Has patient ever been under the extended care of a physician or had any surgeries? ☐ Yes ☐ No

If yes, please explain: _____

Please confirm whether or not the patient has been treated for any of the following:

☐ Yes ☐ No Heart Conditions (murmur, etc.)	☐ Yes ☐ No HIV Positive	☐ Yes ☐ No Hepatitis
☐ Yes ☐ No Excessive Bleeding	☐ Yes ☐ No Tuberculosis	☐ Yes ☐ No Frequent Headaches
☐ Yes ☐ No Diabetes	☐ Yes ☐ No Asthma	☐ Yes ☐ No Kidney Infections
☐ Yes ☐ No Rheumatic Fever	☐ Yes ☐ No Epilepsy	☐ Yes ☐ No Cerebral Palsy
☐ Yes ☐ No Liver Problems	☐ Yes ☐ No Birth Defects	☐ Yes ☐ No Eyesight Problems
☐ Yes ☐ No Cancer	☐ Yes ☐ No Infections	☐ Yes ☐ No Speech Impairments
☐ Yes ☐ No Nervous Disorders	☐ Yes ☐ No ADHD	☐ Yes ☐ No Autism
☐ Yes ☐ No Other_____		

Is the patient currently on any medications? ..... ☐ Yes ☐ No If yes, list: _____

Is the patient allergic to any foods or medicines? ..... ☐ Yes ☐ No If yes, list: _____

Is the patient allergic to any plastics or metals? ..... ☐ Yes ☐ No If yes, list: _____

Is the patient taking or has the patient taken Bisphosphonates (e.g. Fosomax)? ..... ☐ Yes ☐ No

Does the patient need to be medicated prior to dental appointments? ..... ☐ Yes ☐ No

Have tonsils or adenoids been removed? ..... ☐ Yes ☐ No

Are you pregnant? ..... ☐ Yes ☐ No

Dental and Orthodontic History

General Dentist (name of office): _____ Approximate date of last dental cleaning _____

Is there any dental work to be completed? (Fillings,crowns, etc.).	☐ Yes ☐ No	_____
Have there been any injuries to the face, mouth, or teeth?	☐ Yes ☐ No	_____
Has the patient ever sucked their fingers or thumb?	☐ Yes ☐ No	Until what age? _____
Does the patient have any speech problems?	☐ Yes ☐ No	_____
Is the patient a mouth breather while asleep or awake?	☐ Yes ☐ No	_____
Have you been informed of any missing or extra permanent teeth?	☐ Yes ☐ No	_____
Is there pain/popping/clicking in the jaw joint?	☐ Yes ☐ No	When did this begin? _____
Does the patient clench or grind?	☐ Yes ☐ No	_____
Does the patient regularly have headaches?	☐ Yes ☐ No	_____
Does the patient gag easily?	☐ Yes ☐ No	_____
Has the patient ever had orthodontic treatment?	☐ Yes ☐ No	_____
Has the patient ever had a previous orthodontist exam?	☐ Yes ☐ No	_____
Have any family members had orthodontic treatment?	☐ Yes ☐ No	_____

What is the chief concern that brought you to our office? _____

I certify that the above information is complete and accurate.

Patient/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

Health History Update

Patient Initial: _____ Date: _____

Doctor: _____ Date: _____

INFORMED CONSENT

Risks and Limitations of Orthodontic Treatment

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.

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 some discomfort due to the introduction of orthodontic appliances. Nonprescription 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.

Periodontal Disease

Periodontal 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.

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.

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.

_____

Patient Name Date

_____

Signature of Patient/Parent/Guardian Date

_____

Doctor Date

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.

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!

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.

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.

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.

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.

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.

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.

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.

General Consent and Practice Policy

The doctors and staff at this practice are committed to our patient's superior oral health. We follow scientific and ethical principles in order to provide our patients with the highest standard of orthodontic care. We try to create a fun, friendly and comfortable environment and we work hard to keep overall treatment length and appointment times to an absolute minimum. We know you have a choice in orthodontic providers and we hope that these goals are the primary reasons you have chosen our practice. The following practice policies help reinforce these guiding principles.

_____ **Payment/Insurance Policy:** Unless other payment options are arranged through a signed contract with the office, payment in full is due at the time of service. We accept all major credit cards, cash, or personal checks. We cannot guarantee any estimated coverage when billing insurance. Patients are responsible for determining if their insurance is contracted for the services that will be provided. Patients are responsible for any remaining balance not paid by insurance. There will be a $50 service fee on any returned checks. All unpaid balances are subject to a 10% processing fee and may incur a 1.5% monthly finance charge. All delinquent balances must be paid prior to incurring any new charges. Any service overpaid will automatically be refunded to the patient's original payment method within 60 days. Checks will be issued within 60 days from the payment date for patients who made a cash payment.

_____ **Missed or Canceled Appointment Policy:** Due to the busy nature of our practice and as a courtesy to the doctors and staff who are providing care, we ask that you please make your appointments a top priority. If you are unable to make the scheduled appointment, please give us sufficient notice to be able to fill the appointment slot. We ask that you call to reschedule or cancel at least 24 hours in advance. If you miss or break your appointment with less than 24 hours notice, you may be subject to a cancellation fee up to $100. A second last minute cancellation or no-show may lead to the end of the doctor-patient relationship.

_____ **Late Appointment Policy:** We ask that patients be on time for all scheduled appointments in order to fully utilize their appointment time and minimize the impact to other patients scheduled that day. If a patient is more than 10 minutes late to an appointment they may be required to reschedule or asked to wait until after the on-time patients have been seen. Regular tardiness may lead to the end of the doctor-patient relationship.

_____ **Consent to Treat Policy:** I give permission for the practice to perform orthodontic procedures within the scope of dentistry as deemed necessary. I acknowledge that every orthodontic case is unique and understand that occasional adjustments to the original treatment plan may be necessary to achieve the best result. I authorize the provider to use their professional judgment for procedures in addition to or different from those originally contemplated. I have provided as accurate and complete medical history as possible including those antibiotics, drugs, medications, and foods to which my child is allergic.

I give my permission to the following individuals to bring in my child/children to the practice for their appointments that may include any and all dental procedures.

_____ **Communication Policy:** Our top priority is to give you all the information needed to make informed decisions in regards to your/your child's oral health. This includes providing you with recommended procedures, the risks of those procedures, any treatment alternatives, and an estimate of the costs involved to perform those procedures. If you have any concerns about our treatment or policies, please bring them immediately to our attention so that we can resolve any questions and continue to develop a long-term relationship where your/your child's oral health and dental experience is number one for both of us.

_____ **Communication from Harmony Orthodontics:** I give my consent to receive relevant communication from Harmony Orthodontics and its affiliated partners.

_____ **Social Media/Image Consent:** I give consent to use images taken of me/my child to showcase the extraordinary care we have received.

Patient Name _____ Date _____

Parent/Guardian Name (if applicable) _____ Signature (Patient or Parent/Guardian) _____

Relationship to Patient _____