Welcome to WB Orthodontics, PLLC

Date **Reason for today's visit**

Patient's name (Last, First M) **Social Security #**

Date of Birth: **Age:** **Race/ Ethnicity:** **Marital Status:**

If under the age of 18:

Guardian's name (Mom) (Last, First)

Guardian's name (Dad) (Last, First)

Guardian's Marital Status Single Married Divorced Widow

Address City Zip

Occupation #Years Home# Cell #

Employer Work Address Work #

Patient extras:

Nickname School Sport/Hobby

Whom may we thank for referring you to our office? _

Website Sign Mailer Newspaper/Magazine Radio Internet Site

Dental Insurance Information (Insurer)

Insured's Name SS # Relationship to patient

Insurance Co. ID # Group #

Date of Birth Employer Work #

Secondary Insurance (if any)

Insured's Name SS # Relationship to patient

Insurance Co. ID # Group #

Date of Birth Employer Work #

Medical History of patient:

Physician Date of last Visit

Address Phone

Have you been in a hospital during the past 2 years When/Where?

Have you been involved in a serious accident/major operation?

Medications

Any Allergies: Penicillin Sulfa Drugs Codeine Aspirin Other

None Seasonal Food If food, what kind?

Female Patient: Are you pregnant? Nursing?

Female Patient 18 and under: Has menstruation started? What age?

<u>Male/Female</u> Under 18: Height of mother Height of Father

Change in clothes or shoe size in the last 6 months? Yes No

Are you aware that some of your dental appointments will be during school hours? Yes No

Check any of the medical conditions below that patient has had or currently has:

Abnormal Bleeding/Hemophilia	Diabetes	Hepatitis	Pneumonia
Anemia	Arthritis	Asthma	Bone Disorder
Congenital Heart Defect	Epilepsy/Seizure	Heart Murmur	Heart Problem
Kidney Problem	Radiation	Tuberculosis	Tumor/Cancer
Radiation/Chemotherapy	HIV/AIDS	Sinus Problems	High Blood Pressure

Any other medical condition/disability we should know about?

Do you have any disabilities?

<u>Dental History of patient</u>

General Dentist City Date of last visit

Are your teeth sensitive to hot/cold/pressure Where?

Have you ever seen an orthodontist? If yes, who and when?

Dental Habits or Problems Currently/ in the past: (Please circle all that apply)

Grind/Clench Thumb/finger sucking Jaw Joint Pain/Popping/Clicking Nail biting Cheek biting

Lip biting Chewing on pens/pencils/ice Mouth breather Tongue habit/Lisp Other

<u>Benefits</u>

Benefits of Orthodontics: Aesthetics, health, and function. Orthodontics is a service that provides and improvement in the appearance of teeth and general health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment.

I have read and truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorized **<u>Dr. Wakeshi Benson</u>** to perform a complete orthodontic evaluation.

Signature of Patient or legal guardian____Date________________

Help us Go Green!!!!! Please provide an email address ____

Please list name(s) of any person(s) that are **<u>authorized</u>** to bring in patient for Orthodontic appointments:

____

WB ORTHODONTICS
WE TAKE YOUR SMILE PERSONAL

ORTHODONTIC INFORMED CONSENT FOR:___________________________________ to receive orthodontic treatment by Dr. Benson and her team.

The following information is routinely provided to anyone considering orthodontic treatment in our office. While recognizing the benefits of a pleasing smile and healthy teeth, you should also be aware that orthodontic treatment, just as any treatment of the body, has inherent risk and limitations.

These potential complications are seldom sufficient to rule out treatment but should be considered when deciding whether to proceed. Please note that that it is impossible to list every possible circumstance, but the following represents our best estimate of the information you need.

ROOT RESTORATION - In a few cases, the ends of some of the teeth are shortened during treatment. In the event of subsequent gum disease, this shortening could reduce the longevity of affected teeth. Under healthy circumstances, the shortened teeth suffer no disadvantage.

DECALCIFICATION, DECAY OR GUM DISEASE - These problems may occur if the patient does not cooperate with proper brushing and flossing. Additionally, maintaining proper dietary control is essential, especially by minimizing the intake of sugar.

TREATMENT TIME - Our estimated treatment time is our best guess as to how long treatment will take. Progress can be delayed by abnormal facial growth, tooth moving mechanical difficulties, poor appliance wear cooperation, broken appliances and missed appointments.

DEVIATALIZATION - It is possible for the nerve inside a tooth to die during treatment thus requiring a root canal on the affected tooth. The most common cause of this problem is that the tooth received some sort of trauma such as a blow or a large cavity sometime in the past.

TMJ PAIN - Some patients may develop jaw joint noises, discomfort, and facial pain related to the jaw during or after treatment. The current belief is that these problems are caused more by habitual grinding of the teeth rather than the way in which the teeth bite. If such a problem arises, treatment by another specialist may be required.

INJURY FROM APPLIANCES - Some orthodontic appliances , such as a headgear, can be injurious. If any appliances we consider being potentially injurious are prescribed, we will be sure to inform you of this potential and will expect our instructions to be followed carefully.

RETURN OF THE ORIGINAL PROBLEM - We intend to obtain the best result possible. Some orthodontic problems, however, tend to their original condition to a small degree. Careful cooperation during retention phase of treatment will keep this relapse to a minimum.

ADDITIONAL TREATMENT - Unforeseen circumstances (such as abnormal growth or gum disease) may cause us to recommend a form of additional treatment not previously discussed. If this occurs, we will carefully explain the reasons for a change in the treatment plan and any extra fees before proceeding.

CONSENT OF RECORDS - I hereby give my permission for the use of orthodontic records, including photographs for purposes of professional consultations, research, education or publication in professional journals.

I have read the above and have had an opportunity to discuss this information with Dr. Benson. All questions have been answered to my satisfaction. I authorize Dr. Benson and her team to perform the necessary treatment.

****In case where the patient is a minor, I authorize Dr. Benson and her team to perform the necessary treatment in my absence**

Date - Patient: ****Patient/Parent/Legal Guardian:**

Date - Witness: **Witness:** ______________________________

ACKNOWLEDGMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability & Accountability Act of 1997 (HIPPA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly (including taking photographs, X-rays and models before, during and after treatment)
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practice and that I may contact this office at the provided address to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my privacy information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name: Date:

Signature:

Relationship to Patient (If minor):

Dependent family members also covered by this acknowledgment:

For Office Use Only:

We were unable to obtain the patient's written acknowledgment of our Notice of Privacy Practices due to the following reason:

The patient refused to sign Communication barriers

Emergency Situation Other

Photo Release Form

I give my permission for photos of myself/my child, ______________________ to be used in WB Orthodontics advertisements; to include, but not limited to, publications such as local newspapers, marketing flyers/ brochures, office website and video production.

I give my permission for photos of myself/my child, ______________________ to be taken by WB Orthodontics; to be posted on social media, such as, Facebook and Instagram. Photos can also be displayed in office.

I do not wish for any photos of myself/my child, ________________________ to be used in connection with WB Orthodontics advertisement publications.

HIPAA Acknowledgement and Appointment Reminders Form

I __________________understand that WB Orthodontics' staff members may need to contact me with appointment reminders or information related to my treatment via text message, email or voice call. If this contact is to be made by phone, and I am not at home, a message will be left on my answering machine or with anyone who answers the phone. By signing this form, I am giving WB Orthodontics authorization to contact me with these reminders.

Patient, if a minor-Parent/Guardian (Please Print)

Signature: Date: