Welcome to WB Orthodontics, PLLC

Date_____**Reason for today's visit** _____

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

Date of Birth: _____ **Age**: ____ **Race:**_____**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widow

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_____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 Ph #_____

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_____

☐ Seasonal ☐ Food_____

Female Patient: Are you pregnant?_____ Nursing? _____

Female Patient 18 and under: Has menstruation started?_____What age? _____

Male/Female Under 18: Height of mother_____Height of Father_____

Change in clothes or shoe size in the last 6 months?___Y___N

Are you aware that some of your dental appointments will be during school hours?____Y___N

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? _____

Dental History of patient

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 _____

Benefits

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 **Dr. Wakeshi Benson** 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 **authorized** to bring 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: _____**

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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, xrays 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

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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: _____