

Please circle the correct answer

DENTAL HISTORY

Dentist Name: _____ Last visit: _____

Has the treatment plan suggested by the patient's general dentist been finished? Yes No

Has the patient had any tenderness or pain in the jaw joint? Yes No

Do the patient's gums bleed? Yes No

Does the patient do any of the following?

Suck his/her nails: Yes No Suck his/her lips: Yes No Bite his/her nails: Yes No

Have tongue trusting habit: Yes No

MEDICAL HISTORY

How is the patient's general health? : Excellent Good Fair Poor

Is there anything in the patient's medical history that we should be aware: Yes No

If yes, Explain: _____

Name of the patient's physician: _____ Physician's phone number: _____

Is the patient taking any medications? Yes No Name/Dosage _____

Does the patient smoke? Yes No

Is the patient pregnant? Yes No If yes, what week? _____

Is patient allergic to any of the following? :

Dental anesthetics: Yes No Codeine: Yes No

Penicillin: Yes No Erythromycin: Yes No

Aspirin: Yes No Latex Yes No

Tetracycline: Yes No Other: _____

Has the patient ever had any of the following conditions?

Heart Attack	Yes	No	Congenital Heart Def	Yes	No	Prosthesis	Yes	No
Cancer	Yes	No	Diabetes	Yes	No	Rheumatic Fever	Yes	No
Hemophilia	Yes	No	Shingles	Yes	No	Fever Blister	Yes	No
Tuberculosis	Yes	No	Ulcers/Colitis	Yes	No	Drug/Alcohol Abuse	Yes	No
Scarlet fever	Yes	No	Convulsions	Yes	No	Abnormal Bleeding	Yes	No
Anemia	Yes	No	Radiation Treatment	Yes	No	Heart Surgery	Yes	No
Pacemaker	Yes	No	Kidney/Liver Problem	Yes	No	Hospital Stays	Yes	No
Emphysema	Yes	No	Mitral Valve prolapsed	Yes	No	Glaucoma	Yes	No
Asthma	Yes	No	Artificial bones/Joints	Yes	No	Sinus Problems	Yes	No
Artificial Valves	Yes	No	Severe/Frequent Headaches	Yes	No	Difficulty Breathing	Yes	No
Blood transfusion	Yes	No	Venereal Disease	Yes	No	Heart Murmur	Yes	No
Hepatitis A or B	Yes	No	HIV and/or AIDS	Yes	No	Other	_____	

REFERRAL

How did you hear about us?

Doctor Dentist Other patient Insurance Internet Magazine Website Staff

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery, etc.);
- To third party payors or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);
- To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in your treatment;
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;
- To your family and close friends involved in your treatment; and/or,
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect; and,
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

PRIVACY AUTHORIZATION

This Authorization is required by the privacy regulations recently promulgated by the United States Department of Health and Human Services.

Your protected health information, including individually identifiable information, such as names, dates, phone/fax numbers, e-mail addresses, home addresses, social security numbers, demographic data, photographs, x-rays, study models and others (identify specific data) will be used or disclosed for the purpose of (check all that apply):

Lectures/presentations:

Publications:

Research:

Practice Marketing: and/or

Other (specify): _____

This information will be disclosed by the following people: professional.

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This Authorization will expire on _____, 20____.

You have the right to revoke this Authorization at any time in writing. However, your revocation will not be effective to the extent that this Authorization has been relied on. If your treatment will be used for research purpose, we may condition your treatment on obtaining this Authorization, in which case you may not receive treatment.

The information used or disclosed per this authorization may be subject to re-disclosure by the recipient(s) and thus, no longer protected by the privacy rules.

Patient Signature

Print Name

Date

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

PATIENT ACKNOWLEDGMENT

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

Patient

Date

PRIVACY CONSENT

This form is optional under the new patient privacy regulations recently issued by the United States Department of Health and Human Services. We have elected to use this form. Prior to commencing your orthodontic treatment, you should review, sign and date this form.

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office's privacy notice prior to signing this Consent, a copy of which was given to you with this Consent.

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

Thank you for your cooperation. Please let us know if you have any questions.

Patient's Signature

Print Name

Date

ORTHODONTIC INFORMED CONSENT

During Bisphosphonate Treatment

for the Orthodontic Patient

Risks and Limitations of Orthodontic Treatment

The purpose of this document is to inform you of the general risks associated with orthodontic treatment of patients who are now taking, or have taken in the past, medications known as "bisphosphonates." Bisphosphonates are medications prescribed by your physician for the treatment of a variety of difficult medical disorders. Bisphosphonate medication types that you may be taking, or have taken, can be: **Fosamax** (alendronate), **Actonel** (risedronate), **Boniva** (ibandronate), **Skelid** (tiludronate), **Didronel** (etidronate), **Aredia** (pamidronate), or **Zometa** (zoledronic acid). There may be some additional brand names in addition to the above, but they are all known as "bisphosphonates." Every medication has risks and benefits.

All bisphosphonates inhibit osteoclastic (related to bone) activity. They have the ability to, and probably will, inhibit tooth move-

ment during orthodontics. This issue may slow your response to orthodontic movement and lengthen orthodontic treatment time. The effects of these medications may be severe enough to stop tooth movement, which may cause braces to be removed regardless of favorable or unfavorable tooth position. No orthodontist can predict the effect bisphosphonates will have upon an individual's tooth movement.

Long-term bisphosphonate use has been observed to decrease bone healing. It is possible that tooth movement and any surgery procedures performed within the jaws or bone surrounding the teeth may be difficult, and, in some cases, no bone healing may occur.

The risk for developing osteonecrosis is higher for cancer patients on i.v. bisphosphonate therapy.

I have reviewed this notice, and I understand the issues it describes. I have discussed any questions I have with my doctor. I acknowledge I assume these risks and choose to continue with treatment.

Signature of Patient/Parent/Guardian

Date



American Association of Orthodontists