

Just Orthodontics
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Patient Name: _____ D.O.B. _____
Who may we thank for recommending us: _____
Name of Dentist: _____ Date of last visit: _____

MEDICAL HISTORY

Please check if patient has or has had

Y	N		Y	N		Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Joint swelling	<input type="checkbox"/>	<input type="checkbox"/>	Brain Injury	<input type="checkbox"/>	<input type="checkbox"/>	Tonsils Removed
<input type="checkbox"/>	<input type="checkbox"/>	Bone disorders	<input type="checkbox"/>	<input type="checkbox"/>	Kidney or liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Adenoids removed
<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	Sore throats
<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Earaches
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy(convulsions)	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged bleeding			
<input type="checkbox"/>	<input type="checkbox"/>	Emotional Problems	<input type="checkbox"/>	<input type="checkbox"/>	Faintness/Dizziness			

On items checked "Yes" please provide us with a more detailed description: _____

Approximately how much has patient grown in the last year? _____

What would you like to have orthodontic treatment accomplish? _____

List any other serious illness: _____

List any allergies: _____

List drugs or medications now being taken: _____

Do you currently or have you taken bisphosphonate drugs: _____ Explain: _____

Is patient presently under physicians care? _____ Reason: _____

Name of Primary Physician: _____ Other: _____

DENTAL HISTORY

Please check yes or no

Y	N		Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Any injuries to face, mouth, teeth? (circle)	<input type="checkbox"/>	<input type="checkbox"/>	Any teeth removed by extraction?
<input type="checkbox"/>	<input type="checkbox"/>	Thumb, finger, lip, sucking? (circle)	<input type="checkbox"/>	<input type="checkbox"/>	Any difficulty in swallowing or chewing?
<input type="checkbox"/>	<input type="checkbox"/>	More than average amount of decay?	<input type="checkbox"/>	<input type="checkbox"/>	Any pain or clicking on opening mouth?
<input type="checkbox"/>	<input type="checkbox"/>	Any missing permanent teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Is patient adopted? At what age? _____
<input type="checkbox"/>	<input type="checkbox"/>	Any extra permanent teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Does patient visit dentist regularly?
<input type="checkbox"/>	<input type="checkbox"/>	Has an orthodontist been consulted previously? If yes list reason: _____			

Patient's attitude to orthodontic treatment:

Circle one Very motivated Will cooperate if needed Not motivated

Date

Signature of patient or parent or guardian if patient is a minor

INFORMATION FORM

Please Print

Date _____ Patients Full Name _____

Patient or Parent that Authorized Treatment:

Parents Full Name _____

Birthdate _____ Social Security Number _____

Present Street Address _____ years there _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email address _____

Present Employer _____ years there _____

Employer Address _____

City _____ State _____ Zip _____ Phone _____

Position or Title _____

Second Parent

Parents Full Name _____

Birthdate _____ Social Security Number _____

Present Street Address _____ years there _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____

Present Employer _____ years there _____

Employer Address _____

City _____ State _____ Zip _____ Phone _____

Position or Title _____

We are sorry that we cannot accept divorce decrees as assignments of responsibility for a child's orthodontic bills. The parent accompanying the child should pay for the services and seek any reimbursement from the other parent. To the best of my knowledge the above information is complete and correct. I give my permission for any photographs, x-rays, or study models to be used for displays at scientific meetings, presentations, and publications of a scientific nature or for study group purposes to further the art and science of orthodontics. I the undersigned agree to pay for attorney fees and other costs of collecting in the event it becomes necessary to use attorney services to secure payment of this account. I authorize the release of any information relating to treatment to the insurance company and their payment directly to the orthodontist. I understand that I am responsible for all costs of treatment.

_____ Date _____ signature of patient or parent or guardian if patient is a minor

Smile Questionnaire



Patient Name: _____ Date: _____

In order to evaluate your needs and expectations as accurately as possible, please help us by answering the following questions:

Do you feel that your teeth are(circle all responses):

Too small or short?	No	Yes
To large or long?	No	Yes
Crooked or crowded?	No	Yes
Misshaped (uneven/pointed)?	No	Yes
Off Color?	No	Yes

Do you feel your front teeth stick out too much ("Buck teeth")?

No Yes

Are there spaces between your teeth that you do not like?

No Yes

Is there too much or too little gum tissue showing when you smile?

Has there been previous orthodontic treatment (including braces or other appliances)?

No Yes

If so, when and by whom? _____

Are there other dental issues not listed above that you would like to discuss or have treated?

No Yes (explain- other side if needed)

Is there a time of the day/week when you must have an appointment?

Signature: _____ Relationship: _____

Date: _____

ORTHODONTIC INFORMED CONSENT FOR:

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 risks & limitations.

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

ROOT RESORPTION – 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.

ABNORMAL GROWTH – Abnormal growth can upset the most carefully planned treatment. A patient who has grown normally may not continue to do so. If growth becomes disproportionate, the jaw relationship may be seriously affected and original treatment objectives may not be met.

DEVITALIZATION – It is possible for the nerve inside a tooth to die during treatment, thus requiring 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 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 return to their original condition to a small degree. Careful cooperation during the 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 TO USE 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. All questions have been answered to my satisfaction.

Date

Signature of Patient/ Parent

JUST ORTHODONTICS

PATIENT CONSENT/ACKNOWLEDGEMENT FORM

By signing below, you consent to the use and disclosure of your protected health information by Dr. Just, our staff, and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices (“Notice”). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting this office at (920) 682-7616 and requesting a revised Notice. We will also post any revised notice in the office.

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).

This form is also used to obtain acknowledgement of receipt of Our Notice of privacy practices or to document our good faith effort to obtain that acknowledgement.

I have reviewed, understand and agree to the content of the notice of privacy.

Do you give us permission to leave messages on your answering machine:

Yes

No

Do you give us permission to post photographs in our office of pre and/or post treatment:

Yes

No

Name_____

Date_____

Please specify the exact reason why patient chose not to sign the consent/acknowledgement on Notice of Privacy.

HOW DID YOU FIND US?

NAME: _____ DATE: _____

DENTIST NAME: _____

We are interested in finding out what motivated you to select our office for your orthodontic treatment. We are always looking for ways to improve our service to our patients. Thank you in advance for your time!

Please check all that apply.

- My Dentist
- Dental office Staff
- Facebook Recommendation
- I was recommended to you by: _____
- Heard about you through sports, a community activity or a sponsored event. Please specify:
- Someone from your office came to my school to teach dental health
- A staff member of yours referred me. His/Her name is: _____
- Received your postcard
- Saw your sign while driving by
- Radio
- Phone Book/Yellow pages
- Luxury Living Magazine
- Damon System Doctor Locator
- T- Shirt
- Website
- Saw your Cube car
- Promotional item: Water Bottle, Coffee Mug, Beach Ball, Pens etc.