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	
{ }	{ }	Joint swelling	{ }	{ }	Brain Injury	{ }	{ }	Tonsils Removed
{ }	{ }	Bone disorders	{ }	{ }	Kidney or liver disease	{ }	{ }	Adenoids removed
{ }	{ }	Heart trouble	{ }	{ }	Joint Replacement	{ }	{ }	Sore throats
{ }	{ }	Mitral Valve Prolapse	{ }	{ }	Tuberculosis	{ }	{ }	Tonsillitis
{ }	{ }	Rheumatic Fever	{ }	{ }	Anemia	{ }	{ }	Earaches
{ }	{ }	Thyroid problems	{ }	{ }	Epilepsy(convulsions)	{ }	{ }	Arthritis
{ }	{ }	Diabetes	{ }	{ }	Prolonged bleeding			
{ }	{ }	Emotional Problems	{ }	{ }	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	
{ }	{ }	Any injuries to face, mouth, teeth? (circle)	{ }	{ }	Any teeth removed by extraction?
{ }	{ }	Thumb, finger, lip, sucking? (circle)	{ }	{ }	Any difficulty in swallowing or chewing?
{ }	{ }	More than average amount of decay?	{ }	{ }	Any pain or clicking on opening mouth?
{ }	{ }	Any missing permanent teeth?	{ }	{ }	Is patient adopted? At what age? _____
{ }	{ }	Any extra permanent teeth?	{ }	{ }	Does patient visit dentist regularly?
{ }	{ }	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 appiances)?

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 out 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.