Jeffrey K Just, D.D.S., S.C.
340 E. Reed Avenue ~ Manitowoc, WI 54220 l Phone : (920) 684-5878
www.justorthodontics.com

~Please Print~

Patient's Full Name: ______________________ **D.O.B.** __________

Cirlce one: Male Female Patient identifies as: __________

Female Patients: Are you pregnant or anticipating becoming pregnant? Y N

Name of General Dentist: ______________________ Date of last visit: __________

MEDICAL HISTORY

Please check if patient has or not had:

Y N		Y N		Y N		Y N	
{ } { }	Joint Swelling	{ } { }	Kidney or Liver Disease	{ } { }	Tonsils Removed	{ } { }	Diabetes
{ } { }	Bone disorders	{ } { }	Prolonged Bleeding	{ } { }	Brain Injury	{ } { }	Earaches
{ } { }	Heart trouble	{ } { }	Joint Replacement	{ } { }	Tuberculosis	{ } { }	Arthritis
{ } { }	Anemia	{ } { }	Mitral Valve Prolapse	{ } { }	Sore Throats	{ } { }	Tonsillitis
{ } { }	Rheumatic Fever	{ } { }	Epilepsy (convulsions)	{ } { }	Adenoids Removed	{ } { }	Latex Allergy
{ } { }	Thyroid problems	{ } { }	Faintness / Dizziness	{ } { }	Emotional problems		

On all 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/all serious illness: __________

Food/medication allergies: __________

Current medications or drugs: __________

Is the patient currently or ever taken bisphosphonate drugs for bone disorders or cancer? Y N

If yes, please explain: __________

Is patient presently under physicians care? Y N Reason: __________

Name of Primary Physician: __________ Other: __________

DENTAL HISTORY

Please check yes or no

Y N		Y N	
{ } { }	Any injuries to face, mouth, teeth? (circle)	{ } { }	Teeth removed by extraction?
{ } { }	Thumb, finger, lip, sucking? (circle)	{ } { }	Difficulty in swallowing or chewing?
{ } { }	Is patient adopted? At what age? _________	{ } { }	Pain or clicking on opening mouth?
{ } { }	Any missing permanent teeth?	{ } { }	More than average amount of decay?
{ } { }	Any extra permanent teeth?	{ } { }	Does patient visit dentist regularly?

Has an orthodontist been consulted previously? Y N If yes, please explain: __________

Patient's attitude to orthodontic treatment: (*circle one*) very motivated, will copperate if needed ***or*** not motivated

______________________ __________

Signature of patient (***or*** parent or guardian if patient is a minor) Date

JUST ORTHODONTICS INFORMATION FORM

~Please Print~

Patients Full Name: ______________________ **Date:** __________

Parent or Patient Full Name: ______________________

Relationship to patient: ______________________ Birthdate: __________

Present Address: ______________________ Years There: __________

City: ______________ State: ______ Zip: ______ Phone: __________

Email Address: ______________________

Present Employer: ______________________ Years There: __________

Employer Address: ______________________

City: ______________ State: ______ Zip: ______ Phone: __________

Position or Title: ______________________

(2) Parent Full Name **:** ______________________

Relationship to patient: ______________________ Birthdate: __________

Present Address: ______________________ Years There: __________

City: ______________ State: ______ Zip: ______ 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.

______________________________ ______________

Signature of patient **or** parent / guardian if patient is a minor Date

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 voice mail / 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: ______________

Relationship to patient: ______________________________

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

____

____

____

ORTHODONTIC INFORMED CONSENT

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 the 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 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.

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 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 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.

ADDITONAL 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 reason 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.

____ ____________________
Patient/Parent/Legal Guardian Signature Date

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 circle all that apply:

My Dentist

Dental office Staff

I was recommended to you by: ________________________

A staff member of yours referred me: __________________

Through a sport, community activity or a sponsored event…

Please specify: ____________________________________

____

Facebook

Instagram

Website

Car Magnet

Saw your sign while driving by

T- Shirt

Promotional item: Water Bottle, Coffee Mug, Pens etc.