Witherow Orthodontics
New Patient Questionnaire

Name:________________________________Acct #________________Date:____________

The following questions are designed to obtain your health history and to help us understand what you want to achieve from orthodontic treatment. We will confirm this information when we present your treatment options.

HEALTH INFORMATION:
Does the patient have or has the patient ever had any of the following? *(Please check all that apply.)*

__ High/Low Blood Pressure	__ Diabetes	__ Asthma/Hay Fever
__ Rheumatic Fever	__ Venereal Disease/AIDS	__ Epilepsy
__ Hepatitis/Jaundice	__ Fainting Spells/Seizures	__ Radiation Therapy
__ Heart Trouble	__ Arthritis	__Stomach Ulcer

__ Yes __ No Does patient require antibiotics prior to treatment?____________
__ Yes __ No Is patient in good health?
__ Yes __ No Has there ever been trauma to patients face/teeth? Explain______________________
__ Yes __ No Is the patient presently under the care of a physician for an illness or disease?
__ Yes __ No Does the patient have a bleeding tendency or do wounds heal slowly?
__ Yes __ No Has the patient been on Fosamax or any Bisphosphonates(drugs that harden bone)?
__ Yes __ No Is the patient allergic to nickel, latex, any drugs or medications? List: ________________

MY CHIEF CONCERNS ARE:____

CHECK ALL STATEMENTS BELOW THAT APPLY TO THE PATIENT:

The Teeth

__ There are spaces between the teeth that I do not like.
__ The teeth are crooked and overlapping.
__ The teeth stick out too far.
__ The mouth seems too small, not enough room for the teeth.
__ The teeth are coming in the wrong places.

The Bite

__ The bite is comfortable and I can eat what I want with no difficulties.
__ I feel there is a problem with the bite or I have been told there is a problem.
__ I have frequent or chronic pain in my jaws, face or head.
__ My jaws click, pop, or lock when I open my mouth.
__ I have or have had difficulty in opening and/or closing my jaws.
__ I clench my teeth during the day or grind my teeth during the night.
__ There is a habit I am concerned about (thumb, finger sucking).

The Dentist

__ I visit the dentist regularly, at least every _____ months.
__ My last cleaning was in the month of ______________.
__ My family dentist (group) is ___________________________. Phone (____) _____-_______.
__ I have not seen the dentist for over a year. I am due for a cleaning.
__ It has been _____ years since I had my teeth checked by the dentist.

Dental Problems

__ I have no dental problems that I am aware of other than misaligned teeth.
__ I am aware of other dental problems that need attention.____________

-More-

The Orthodontist

__ This is my first experience with an orthodontist.
__ The patient has worn braces before.___________(year)
__ Someone in the family has worn braces.______________(who)
__ I have seen another orthodontist and I would like a second opinion. ____________________(Dr. Name)

What I Expect from Orthodontic Treatment

__ I want to find out if any treatment is needed.
__ I only want the upper teeth straightened and aligned.
__ I only want the lower teeth straightened and aligned.
__ I want the upper and lower teeth straightened and aligned.
__ I want all the teeth straightened and the bite corrected if possible.

How Much Time are You Willing to Commit to Orthodontic Treatment?

__ I am willing to commit as much time and resources as required, even if surgery is needed, to get the best cosmetic and functional results.
__ I want the best results that can be obtained without any facial surgery.
__ I want to spend as little time as possible and am willing to accept compromises.

What Kind of Braces Do You Want?

__ The least expensive (silver metal)
__ The most cosmetic (clear ceramic)
__ Removable and cosmetic (Invisalign)
__ I need more information to make a decision.

Cost and Payment Plans

__ I am interested in saving the most money by paying for the total treatment at the beginning.
__ I am interested in making a down payment to reduce the total costs. $_________(amount)
__ I am looking for a payment plan with monthly payments of $________ per month.
__ I am wanting to use my care credit card

Insurance

__ I have insurance that may pay for a portion of the treatment costs.______________(provider)
__ I have no insurance that covers orthodontic treatment.

How Soon Would You Like to Get Started?

__ I would like to get started as soon as possible if it is determined that treatment is indicated.
__ I want to discuss the findings with my spouse before making a decision to start treatment.
__ I want to delay treatment as long as possible.

NAME__________ GENDER_____ DATE__________
ADDRESS__________ CITY__________ STATE____ ZIP________
HOME PHONE: (____)________ WORK:(___)________ AGE____ BIRTHDATE________
RESPONSIBLE PARTY__________ RELATIONSHIP TO RESPONSIBLE PARTY ________
ADDRESS FOR STATEMENTS(IF DIFFERENT)__________
CITY__________ STATE_____ ZIP_____ EMAIL__________
HAS ANY FAMILY MEMBER BEEN A PATIENT HERE BEFORE? _____ NAME__________
HAS ANY FAMILY MEMBER WORE BRACES BEFORE? ______
WHO WAS THE ORTHODONTIST? __________
EMERGENCY CONTACT __________ RELATIONSHIP________
ADDRESS________ CITY________ STATE____ ZIP______
PHONE (____)________

WHEN WAS THE LAST TIME YOU VISITED A DENTIST OFFICE ?______ DENTIST______
HOW MANY WAYS HAVE YOU HEARD OF OUR OFFICE? (check all that apply) ___ Friend Name __________
___Yellow Pages ___Staff Member ___Family Member___Insurance Company
___Dentist___Internet____Google ____ Angie's List ___Driving By ____
I REALIZE IT MAY BE APPROPIATE TO UTILIZE A CREDIT REPORT IN DETERMINING
PAYMENT PLAN. SIGNATURE (Reponsible Party) __________ DATE________

IF PATIENT IS AN ADULT:

EMPLOYER:__________	SPOUSE:__________
ADDRESS__________	EMPLOYER__________
POSITION__________	ADDRESS__________
PHONE NUMBER (___)__________	PHONE NUMBER(___)__________
SOCIAL SECURITY #__________	SOCIAL SECURITY # __________

IF A PATIENT IS A CHILD:

FATHER __________	MOTHER__________
EMPLOYER__________	EMPLOYER__________
POSITION__________	POSITION__________
WORK PHONE # (___)__________	WORK PHONE #(___)__________
SOCIAL SECURITY # __________	SOCIAL SECURITY #__________

MARITAL STATUS____MARRIED___SEPARATED____DIVORCED_____WIDOWED

ORTHODONTIC INSURANCE INFORMATION

PRIMARY INSURANCE	**SECONDARY INSURANCE**
POLICY HOLDER__________	POLICY HOLDER__________
BIRTHDATE ______ EMPLOYER________	BIRTHDATE______ EMPLOYER________
INSURANCE COMPANY__________	INSURANCE COMPANY__________
INSURANCE PHONE (___)__________	INSURANCE PHONE (__)__________
ADDRESS__________	ADDRESS__________
POLICY / GROUP # __________	EMPLOYEE ID#__________
POLICY /GROUP # __________	EMPLOYEE ID#__________

INSURANCE AND PAYMENT AUTHORIZATION RELEASE
I AUTHORIZE THE RELEASE OF ANY INFORMATION RELATING
TO THIS CLAIM AND UNDERSTAND THAT I AM RESPONSIBLE
FOR ALL COSTS OF DENTAL TREATMENT.____________________
SIGNATURE (RESPONSIBLE PARTY) DATE

I HEARBY AUTHORIZE PAYMENT DIRECTLY TO
WITHEROW ORTHODONTICS INC. OF THE GROUP INSURANCE
BENEFITS OTHERWISE PAYABLE TO ME.____________________
SIGNATURE (RESPONSIBLE PARTY) DATE

Dr. Donald Shane Witherow, DDS, MS
Witherow Orthodontics

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WITHEROW ORTHODONTICS
PATIENT INFORMATION AND CONSENT

Positive orthodontic results can be achieved by an informed and cooperative patient; therefore the following information is routinely supplied to all who consider orthodontic treatment. While recognizing the benefits of healthy teeth and a pleasing smile, you should also be aware that orthodontic treatment has limitations and potential risks. These are seldom enough to avoid treatment, but should be considered in making the decision to undergo orthodontic treatment. Orthodontic treatment usually proceeds as planned; however, like all areas of the healing arts, results cannot be guaranteed.

Benefits of Orthodontic Treatment
Orthodontics plays an important role in improving overall oral health, and in achieving balance and harmony between the teeth and face for a beautiful, healthy smile. An attractive smile enhances one's self esteem, which may actually improve the quality of life itself. Properly aligned teeth are easier to brush, which decreases the tendency to decay or to develop diseases of the gums and supporting bones.

Potential Risks of Orthodontic Treatment
As with all forms of medical and dental treatment, orthodontics has some risks and limitations. Fortunately, in orthodontics complications are infrequent and, when they do occur, they are usually of minor consequence. Nevertheless, they should be considered when making the decision to undergo orthodontic treatment. The major risks involved in orthodontic treatment may include the following:

1. **Tooth Decay (decalcification):** Tooth discoloration or decay can occur on the teeth if an orthodontic patient eats food containing excessive sugar and does not brush the teeth properly. These same problems occur without orthodontic treatment, but the risk is greater to an individual wearing braces. Good oral hygiene is a must during orthodontic treatment to prevent problems.

2. **Tooth Root Shortening:** Some patients are prone to the roots of their teeth being shortened during orthodontic treatment, some are not. This usually does not have significant consequences, but in the presence of gum problems and bone loss, it may become a threat to the long-term health of the teeth involved.

3. **Periodontal Disease (gum disease):** The health of the bone and gums which support the teeth may be affected by orthodontic tooth movement if a condition already exists and in some rare cases where a condition doesn't appear to exist. Proper brushing and flossing can usually prevent swollen, inflamed, and bleeding gums. Periodontal disease is usually caused by the accumulation of plaque and debris around the teeth and gums, but there are some unknown causes that can also lead to progressive loss of the supporting bones and gums. It is important that the patient have regular cleanings and dental check-ups during orthodontic treatment. If gum disease should become uncontrollable, orthodontic treatment would have to be discontinued prior to completion.

4. **Relapse (teeth shift after being straightened):** Teeth have a tendency to change their positions after orthodontic treatment. There is usually only a minor change and faithful wearing of retainers at night for an indefinite period should help reduce this tendency. Throughout life the bite can change from various causes (eruption of wisdom teeth, growth and/or aging, mouth breathing, and other oral habits) all of which are outside the control of the orthodontist.

5. **Jaw Joint Problems (TMJ):** Patients with bad bites have a high potential to TMJ or jaw joint problems. These problems may be present before orthodontic treatment and symptoms may develop during or after orthodontic treatment. TMJ problems will occur with or without orthodontic treatment. TMJ symptoms include joint stiffness, limited jaw motion, facial pain, ear pain, dizziness, headaches and neck aches. There is no guarantee that orthodontic treatment will correct or prevent TMJ symptoms. Any of the above noted symptoms should be promptly reported to the orthodontist.

6. **Loss of Tooth Vitality:** Sometimes a tooth may have been traumatized by a previous accident or a tooth may have a large filling, which can cause damage to the nerve of the tooth. Orthodontic tooth movement may aggravate this condition and, in rare instances, may lead to root canal treatment. This type of treatment is not covered in your orthodontics and is done by another specialist, if needed.

7. **Minor Injuries:** Dental instruments may inadvertently scratch, poke, or hit a tooth causing potential damage to or soreness of affected oral structures. On rare occasions, parts of orthodontic appliances may be accidentally swallowed or aspirated and the gums, cheeks and lips may be scratched or irritated by loose or broken appliances or by blows/bumps to the mouth. We will use extreme care to avoid minor injuries.

8. **Headgear Instructions:** (If headgear is necessary) Improperly handled, headgear may cause injury. There have been a few reports of injury to the eyes of patients wearing headgear. Patients are cautioned not to wear a headgear during times of horseplay or competitive activity. Although our headgear is equipped with a safety system, we urge caution at all times.

9. **Adjunctive Surgery:** Sometimes oral surgery (tooth removal or jaw surgery) is necessary in conjunction with orthodontic treatment, especially to correct crowding or severe jaw imbalances. Risk involved with anesthesia or any surgical treatment should be discussed with your general dentist or oral surgeon before making your decision to proceed with surgery.

10. **Unfavorable Growth:** Insufficient, excessive, or abnormal changes in growth of the jaws may limit our ability to achieve the desired result. If growth becomes disproportionate during or after treatment, or if a tooth forms very late, the bite may change requiring additional treatments or, in some cases, surgery. Growth disharmony and unusual tooth formations are biological processes beyond the orthodontist's control. Growth changes that occur after orthodontic treatment may alter the quality of the treatment results.

11. **Treatment Time:** the total time required to complete treatment may exceed the original estimate. Excessive or deficient bone growth, poor cooperation in wearing a removable appliance the required hours per day, poor oral hygiene, broken appliances and missed appointments can lengthen the treatment time and affect the quality of the treatment results.

12. **Adjunctive Dental Care:** Due to the wide variation in the size or shape of teeth, achievement of the most ideal result (for example, complete closure of excessive space) may require restorative dental treatment. The most common types of treatment are cosmetic bonding, crown and bridge restorative dental care and/or periodontal therapy. You are encouraged to ask questions regarding dental and medical care adjunctive to orthodontic treatment of these doctors who provide these services.

13. **Medical Problems:** General medicine problems can affect orthodontic treatment. You should keep your orthodontist informed of any changes in your medical health.

Alternatives to Orthodontic Treatment

For the vast majority of patients, orthodontic treatment is an elective procedure. One possible alternative to orthodontic treatment is no treatment at all. You could choose to accept your present oral condition.

Notes:____

____

Acknowledgement of Informed Consent

I have read this form and hereby acknowledge the major treatment considerations and potential risks that may or may not occur during orthodontic treatment. The doctor and staff have answered all my questions about proposed treatment/ risks and presented information to aid in my decision making process. I have received a copy of this Information and Consent form and hereby consent to orthodontic treatment.

____

Patient Name (please print)

___________________________________ _______________

Patient/Responsible Party Signature Date

Patient Consent for Use and Disclosure of Protected Health Information

I have read the Notice of Privacy Practices and hereby give my consent for Witherow Orthodontics to use and disclose health information (PHI) about me/my child to carry out treatment, payment and healthcare operations (TPO).

___________________________________ _______________

Patient/Responsible Party Signature Date

Witherow Orthodontics

Privacy is important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I reveived a copy of the Notice of Privacy Practices of Witherow Orthodontics. I hereby authorize, as indicated by my signature below, Witherow Orthodontics to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

____________________________ ____
Print Name Address

____________________________ ____________________________
Signature Date

Please check your preferred means of communication:

________You may contact me at my home telephone number: ____________________

________You may contact me at my mobile telephone number: ____________________

________You may contact me at my work telephone number: ____________________

________You may send me an email at: ______________________________________

________Other: __________________________

Please list authorized persons with whom we may discuss your Protected Health Information (PHI). Please notify us if you desire to remove a name from this list in the future. **(circle:)**

1. _____________ Relationship: ____________ Date __/__/____ added/removed
2. _____________ Relationship: ____________ Date __/__/____ added/removed
3. _____________ Relationship: ____________ Date __/__/____ added/removed
4. _____________ Relationship: ____________ Date __/__/____ added/removed

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign

____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining the acknowledgement

_____ Other (Please Specify)

Staff Person Initials __________