



**HERMITAGE**

107 Bonnahbrook Dr.  
Hermitage, TN 37076

**LEBANON**

1424 W Baddour Pkwy, Suite A,  
Lebanon, TN 37087

**MT. JULIET**

1323 Clearview Dr.  
Mt. Juliet, TN 37122

**NASHVILLE**

224 11th Avenue South  
Nashville, TN 37203

WitherowOrthodontics.com | P 615-754-2027 F 615-553-2363

# NEW PATIENT QUESTIONNAIRE

Name \_\_\_\_\_ Acct# \_\_\_\_\_ Date \_\_\_\_\_

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

## HEALTH INFORMATION

Does the patient have or has the patient ever had any of the following?

- 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

Does the patient require antibiotics prior to treatment? Please list \_\_\_\_\_  Yes  No

Is the patient in good health?.....  Yes  No

Has there ever been trauma to patient's 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? Please list \_\_\_\_\_  Yes  No

My chief concerns are \_\_\_\_\_

## CHECK ALL STATEMENTS BELOW THAT APPLY TO THE PATIENT

### The teeth

- There are spaces between the teeth that the patient does 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 the patient can eat with no difficulties.
- The patient feels there is a problem with the bite or has been told there is a problem.
- The patient has frequent or chronic pain in their jaws, face or head.
- The patient's jaws click, pop or lock when they open their mouth.
- The patient has or has had difficulty in opening and/or closing their jaws.
- The patient clenches their teeth during the day or grinds their teeth during the night.
- There is a habit I am concerned about (thumb or finger sucking).

### The dentist

The patient's dentist (group) is \_\_\_\_\_.

- The patient visits the dentist regularly, at least every \_\_\_\_\_ months.
- The patient's last cleaning was in the month of \_\_\_\_\_.
- The patient has not seen the dentist for over a year. They are am due for a cleaning.
- It has been \_\_\_\_\_ years since the patient had their teeth checked by the dentist.

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## NEW PATIENT QUESTIONNAIRE *(continued)*

**CHECK ALL STATEMENTS BELOW THAT APPLY TO THE PATIENT****Dental problems**

- The patient is not aware of dental problems other than misaligned teeth.
- The patient is aware of other dental problems that need attention. If so, what are they? \_\_\_\_\_

**The orthodontist**

- This is the patient's first experience with an orthodontist.
- The patient has worn braces before. \_\_\_\_\_ (year)
- Someone in the family has worn braces. \_\_\_\_\_ (who)
- The patient has seen another orthodontist, and would like a second opinion. \_\_\_\_\_ (Dr. Name)

**Patient expectations of orthodontic treatment**

- The patient wants to find out if any treatment is needed.
- The patient only wants the upper teeth straightened and aligned.
- The patient only wants the lower teeth straightened and aligned.
- The patient wants the upper and lower teeth straightened and aligned.
- The patient wants all the teeth straightened and the bite corrected if possible.

**What kind of braces does the patient want?**

- Silver metal
- Clear ceramic
- 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 looking for a payment plan with monthly payments of:
  - \$100–\$150
  - \$150–\$200
  - \$200–\$250
  - \$250 or more
- I am wanting to use my CareCredit card.

**How much time are you willing to commit to orthodontic treatment?**

- 0–6 months
- 6–12 months
- 12–18 months
- As long as necessary without any facial surgery
- As long as necessary even if surgery is needed to obtain the best cosmetic and functional results

**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 necessary.
- 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.



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# PATIENT REGISTRATION

## PATIENT INFORMATION

Name \_\_\_\_\_ Gender \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Home / Cell \_\_\_\_\_ Work \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Responsible Party \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Address for Statements (if different) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Email \_\_\_\_\_  
 Has any family member been a patient here before?  Yes  No If so, who? \_\_\_\_\_  
 Has any family member worn braces before?  Yes  No If so, who was the orthodontist? \_\_\_\_\_

## EMERGENCY CONTACT

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Phone \_\_\_\_\_

## IF PATIENT IS A MINOR

Parent 1 _____	Parent 2 _____
Employer _____	Employer _____
Position _____	Position _____
Address _____	Address _____
City _____ State _____ ZIP _____	City _____ State _____ ZIP _____
Phone _____	Phone _____
Soc. Sec. Number _____	Soc. Sec. Number _____
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	

## IF PATIENT IS AN ADULT

Employer _____	Spouse _____
Position _____	Employer _____
Address _____	Address _____
City _____ State _____ ZIP _____	City _____ State _____ ZIP _____
Phone _____	Phone _____
Soc. Sec. Number _____	Soc. Sec. Number _____

## OTHER QUESTIONS

Date of Last Dental Visit \_\_\_\_\_ Dentist \_\_\_\_\_  
 How did you hear about our office? (check all that apply)  
 Friend \_\_\_\_\_  Google  Facebook  Insurance Company  Driving By  
 Family Member \_\_\_\_\_  Yellow Pages  Yelp  Dentist  Other \_\_\_\_\_

## CREDIT REPORTING

I realize it may be appropriate to utilize a credit report in determining payment plan.  
 Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

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# PATIENT REGISTRATION *(continued)*

**INSURANCE**

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**Primary Insurance**

Policy Holder \_\_\_\_\_  
Birthdate \_\_\_\_\_ Employer \_\_\_\_\_  
Insurance Co. \_\_\_\_\_  
Insurance Phone \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Policy / Group # \_\_\_\_\_  
Employee ID # \_\_\_\_\_

**Secondary Insurance**

Policy Holder \_\_\_\_\_  
Birthdate \_\_\_\_\_ Employer \_\_\_\_\_  
Insurance Co. \_\_\_\_\_  
Insurance Phone \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
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

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

I hereby authorize payment directly to Witherow Orthodontics Inc. of the group insurance benefits otherwise payable to me.

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

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## 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

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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

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As with all forms of medical and dental treatment, orthodontics has some risks and limitations. Fortunately, complications in orthodontics 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 any 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 for 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 neckaches. 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.

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## PATIENT INFORMATION AND CONSENT *(continued)*

- 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 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 and 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 the 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 \_\_\_\_\_  
\_\_\_\_\_

### ACKNOWLEDGMENT 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) \_\_\_\_\_

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).

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_



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# ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

I reviewed 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.

Name (please print) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**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.**

- 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 Member Initials \_\_\_\_\_ Date \_\_\_\_\_