PENINSULA ORTHODONTICS
DR. STEVEN REESE

Specialist in Orthodontics and Dentofacial Orthopedics

PATIENT INFORMATION

Date_____

Patient's name _____
Last First Middle

Address _____
Street City Zip

Home Phone_____ Patient's cell phone _____Birthdate_____

If patient is a minor, give parent's or guardian's name _____

Who does the patient live with?_____

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

How long at this address?_____ Home phone_____ Work phone _____

Cell/other phone_____ Email address_____

Social Security #_____ Birthdate_____ Relationship to Patient _____

Employer_____ Occupation_____ No. years employed_____

Spouse's Name_____ Relationship to Patient _____

Employer_____ Occupation_____ No. years employed_____

Social Security # _____ Birthdate _____Work Phone_____

Cell/other phone_____ Email address _____

DENTAL INSURANCE INFORMATION

Insured's Name_____ Insured's Social Security # _____

Insurance Company_____ ID#._____ DOB._____

Insurance Co. Address_____ Phone No. _____

Do you have dual coverage? Yes_____ No_____

EMERGENCY INFORMATION

Name of nearest relative or friend not living with you _____Phone_____

Complete address _____
Street City Zip

401 Oyster Point Road, Suite D, Newport News, VA 23602
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www.peninsulabraces.com ✦ info@peninsulabraces.com

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MEDICAL HISTORY

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medications? _____
Yes No Are you allergic to any medications? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any operations? _____
Yes No Have you ever been involved in a serious accident? _____
Yes No Have you seen a physician in the last 12 months? Why? _____

Physician _____ Date of Last Visit _____

Circle any of the medical conditions below that you have had or currently have.

Abnormal Bleeding	Diabetes	Herpes	Pneumonia
ADD/ADHD	Endocrine Disorder	High Blood Pressure	Psychological Issues
Anemia	Epilepsy/Seizures	HIV/AIDS	Radiation/Chemotherapy
Arthritis	Fainting or Dizziness	Immune Disorders	Rheumatic Fever
Asthma	Gastrointestinal Disorders	Kidney Disease	Speech Problems
Bone Disorders/Osteoporosis	Heart Disease	Liver Disease	Snoring
Congenital Heart Defect	Heart Murmur	Mouth Breathing	Tuberculosis
Developmental Delays	Hepatitis	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

DENTAL HISTORY

General Dentist _____ Date of last visit _____
What concerns you most about your teeth? _____

Yes No Are you presently in any tooth, gum or mouth pain? _____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have you ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No Do your gums bleed when you brush? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Are you a mouth breather? _____
Yes No Have you ever seen an orthodontist? If yes, who and when? _____
Yes No What is your attitude toward receiving orthodontic treatment? _____
Yes No Has anyone in your family received orthodontic treatment? _____
How did they feel about the result? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
Yes No Are you aware of your jaw clicking or popping? _____
Yes No Are you aware of clenching your teeth during the day? _____
Yes No Have you ever been told that you grind your teeth? _____
Yes No Do you have “tension” headaches? _____
Yes No Have you ever experienced chronic ringing in your ears? _____

Female Patients only:

Yes No Are you pregnant? _____
Yes No Has menstruation started? _____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Reese to perform a complete orthodontic evaluation.

Signature: _____ Date: _____

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CONSENT FOR TREATMENT

Results of Treatment: Orthodontic treatment usually proceeds as planned, and we intend to do everything possible to achieve the best results for every patient. However, we cannot guarantee that you will be completely satisfied with your results, nor can all complications or consequences be anticipated. The success of treatment depends on your cooperation in keeping appointments, maintaining good oral hygiene, avoiding loose or broken appliances, and following the orthodontist's instructions carefully.

Length of Treatment: The length of treatment depends on a number of issues, including the severity of the problem, the patient's growth and the level of patient cooperation. The actual treatment time is usually close to the estimated treatment time, but treatment may be lengthened if, for example, unanticipated growth occurs, if there are habits affecting the dentofacial structures, if periodontal or other dental problems occur, or if patient cooperation is not adequate. Therefore, changes in the original treatment plan may become necessary. If treatment time is extended beyond the original estimate, additional fees may be assessed.

Discomfort: The mouth is very sensitive so you can expect an adjustment period and some discomfort due to the introduction of orthodontic appliances. Non-prescription pain medication can be used during this adjustment period.

Relapse: Completed orthodontic treatment does not guarantee perfectly straight teeth for the rest of your life. Retainers will be required to keep your teeth in their new positions as a result of your orthodontic treatment. You must wear your retainers as instructed or teeth may shift, in addition to other adverse effects. Regular retainer wear is often necessary for several years following orthodontic treatment. However, changes after that time can occur due to natural causes, including habits such as tongue thrusting, mouth breathing, and growth and maturation that continue throughout life. Later in life, most people will see their teeth shift. Minor irregularities, particularly in the lower front teeth, may have to be accepted. Some changes may require additional orthodontic treatment or, in some cases, surgery. Some situations may require non-removable retainers or other dental appliances.

Extractions: Some cases will require the removal of deciduous (baby) teeth or permanent teeth. There are additional risks associated with the removal of teeth which you should discuss with your family dentist or oral surgeon prior to the procedure.

Orthognathic Surgery: Some patients have significant skeletal disharmonies which require orthodontic treatment in conjunction with orthognathic (dentofacial) surgery. There are additional risks associated with this surgery which you should discuss with your oral and/or maxillofacial surgeon prior to beginning orthodontic treatment. Please be aware that orthodontic treatment prior to orthognathic surgery often only aligns the teeth within the individual dental arches. Therefore, patients discontinuing orthodontic treatment without completing the planned surgical procedures may have a malocclusion that is worse than when they began treatment.

Decalcification and Dental Caries: Excellent oral hygiene is essential during orthodontic treatment as are regular visits to your family dentist. Inadequate or improper hygiene could result in cavities, discolored teeth, periodontal disease and/or decalcification. These same problems can occur without orthodontic treatment, but the risk is greater to an individual wearing braces or other appliances. These problems may be aggravated if the patient has not had the benefit of fluoridated water or its substitute, or if the patient consumes sweetened beverages or foods.

Root Resorption: The roots of some patients' teeth become shorter (resorption) during orthodontic treatment. It is not known exactly what causes root resorption, nor is it possible to predict which patients will experience it. However, many patients have retained teeth throughout life with severely shortened roots. If resorption is detected during orthodontic treatment, your orthodontist may recommend a pause in treatment or the removal of the appliances prior to the completion of orthodontic treatment.

Nerve Damage: A tooth that has been traumatized by an accident or deep decay may have experienced damage to the nerve of the tooth. Orthodontic tooth movement may, in some cases, aggravate this condition. In some cases, root canal treatment may be necessary. In severe cases, the tooth or teeth may be lost.

Periodontal Disease: Periodontal (gum and bone) disease can develop or worsen during orthodontic treatment due to many factors, but most often due to the lack of adequate oral hygiene. You must have your general dentist, or if indicated, a Periodontist monitor your periodontal health during orthodontic treatment every three to six months. If periodontal problems cannot be controlled, orthodontic treatment may have to be discontinued prior to completion.

Injury from Orthodontic Appliances: Activities or foods which could damage, loosen or dislodge orthodontic appliances need to be avoided. Loosened or damaged orthodontic appliances can be inhaled or swallowed or could cause other damage to the patient. You should inform your orthodontist of any unusual symptoms or of any loose or broken appliances as soon as they are noticed. Damage to the enamel of a tooth or to a restoration (crown, bonding, veneer, etc.) is possible when orthodontic appliances are removed. This problem may be more likely when esthetic (clear or tooth colored) appliances have been selected. If damage to a tooth or restoration occurs, restoration of the involved tooth/teeth by your dentist may be necessary.

Headgear: Orthodontic headgears can cause injury to the patient. Injuries can include damage to the face or eyes. In the event of injury or especially an eye injury, however minor, immediate medical help should be sought. Refrain from wearing headgear in situations where there may be a chance that it could be dislodged or pulled off. Sports activities and games should be avoided when wearing orthodontic headgear.

Temporomandibular (Jaw) Joint dysfunction: Problems may occur in the jaw joints, i.e., temporomandibular joints (TMJ), causing pain, headaches or ear problems. Many factors can affect the health of the jaw joints, including past trauma (blows to the head or face), arthritis, hereditary tendency to jaw joint problems, excessive tooth grinding or clenching, poorly balanced bite, and many medical conditions. Jaw joint problems may occur with or without orthodontic treatment. Any jaw joint symptoms, including pain, jaw popping or difficulty opening or closing, should be promptly reported to the orthodontist. Treatment by other medical or dental specialist may be necessary.

Impacted, Ankylosed, Unerupted Teeth: Teeth may become impacted (trapped below the bone or gums), ankylosed (fused to the bone) or just fail to erupt. Often times, these conditions occur for no apparent reason and generally cannot be anticipated. Treatment for these conditions depends on the particular circumstance and the overall importance of the involved tooth, and may require extraction, surgical exposure, surgical transplantation or prosthetic replacement.

Occlusal Adjustment: You can expect minimal imperfections in the way your teeth meet following the end of treatment. An occlusal equilibration procedure may be necessary, which is a grinding method used to fine-tune the occlusion. It may also be necessary to remove a small amount of enamel in between the teeth thereby "flattening" surfaces in order to reduce the possibility of a relapse.

Non-Ideal Results: Due to the wide variation in the size and shape of the teeth, missing teeth, etc., achievement of an ideal result (for example, complete closure of a space) may not be possible. Restorative dental treatment, such as esthetic bonding, crowns or bridges or periodontal therapy, may be indicated. You are encouraged to ask your orthodontist and family dentist about adjunctive care.

Third Molars: As third molars (wisdom teeth) develop, your teeth may change alignment. Your dentist and/or orthodontist should monitor them in order to determine when and if the third molars need to be removed.

Allergies: Occasionally patients can be allergic to some of the component materials of their orthodontic appliances. This may require a change in treatment plan or discontinuance of treatment prior to completion. Although very uncommon, medical management of dental material allergies may be necessary.

General Health Problems: General health problems such as bone, blood, or endocrine disorders, and many prescription and non-prescription drugs (including bisphosphonates) can affect your orthodontic treatment. It is imperative that you inform your orthodontist of any changes in your general health status.

Use of Tobacco Products: Smoking or chewing tobacco has been shown to increase the risk of gum disease and interferes with healing after oral surgery. Tobacco users are also more prone to oral cancer, gum recession, and delayed tooth movement during orthodontic treatment. If you use tobacco, you must carefully consider the possibility of a compromised orthodontic result.

ACKNOWLEDGMENT

I hereby acknowledge that I have read and fully understand the treatment considerations and risks presented in this form. I also understand that there may be other problems that occur less frequently than those presented, and that actual results may differ from the anticipated results. I also acknowledge that I have discussed any concerns I may have with the orthodontist, and have been given the opportunity to ask any questions. I have been asked to make a choice about treatment. I hereby consent to the treatment proposed by and authorize Dr. Steven Reese and Peninsula Orthodontics to provide the treatment. I also authorize Peninsula Orthodontics to provide my health care information to my other health care providers. I understand that my treatment fee covers only treatment provided by Peninsula Orthodontics and that treatment provided by other dental or medical professionals is not included in the fee for my orthodontic treatment.

CONSENT TO UNDERGO ORTHODONTIC TREATMENT

I hereby consent to the making of diagnostic records, including x-rays, before, during and following orthodontic treatment, and to the doctor and where appropriate, staff providing orthodontic treatment prescribed by the doctor, for the individual named below. I fully understand all of the risks associated with the treatment.

*Printed Name of Patient*_____

_____*Date*_____ _____*Date* _____

Signature of Patient/Parent/Guardian *Witness*

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I hereby authorize Peninsula Orthodontics to provide other health care providers with information regarding the above individual's orthodontic care as deemed appropriate. I understand that once released, the doctor and staff have no responsibility for any further release by the individual receiving this information.

CONSENT TO USE OF RECORDS

I hereby give my permission for the use of orthodontic records, including photographs, made in the process of examinations, treatment and retention for purposes of professional consultation, research, education, or publication in professional journals.

_____*Date*_____ _____*Date* _____

Signature of Patient/Parent/Guardian *Witness*

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PRIVACY CONSENT

This form is required by the new patient privacy regulations issued by the United States Department of Health and Human Services. Prior to commencing your orthodontic treatment, you must review, sign, and date this form.

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, e-mail addresses and demographic data) may be used in connection with your treatment, payment on your account or to certifying licensing and accrediting bodies.

You have the right to review our office's Privacy Notice prior to signing this Consent Form. A copy is available on request.

You have the right to request restrictions on the use of your protected health information, however we are not required to honor your request.

We may amend the attached Privacy Notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this consent.

Thank you for your cooperation. Please let us know if you have any questions.

_____
Patient or Parent/Guardian Signature

_____
Print Patient's Name

_____
Date

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AUTHORIZATION TO RELEASE DENTAL INFORMATION

(The execution of this form does not authorize the release of information other than the terms specifically described below.)

TO: Peninsula Orthodontics PATIENT NAME:_____
FAX: _____ DOB: _____ SSN:_____
RELEASE TO:_____
_____

I request and authorize the above-named doctor or health care provider to release the information specified below to the organization, agency or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

INFORMATION REQUESTED: DATES COVERED: Duration of Orthodontic Treatment at Peninsula Orthodontics

Limited to treatment dates and for : Duration of Orthodontic Treatment at Peninsula Orthodontics
_____Copy of complete dental chart condition described below:
_____Copy of dental x-rays
_____All treatment rendered _____
_____Financial Records regarding patient account
_____Authorized to make payments to patient account.
_____Others (e.g. models—describe)

PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED:
_____Transfer of Records _____Second Opinion _____Financial
_____Other, please explain_____

AUTHORIZATION: *I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time, except to the extent that action has already been taken to comply with it. With my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event: on_____(date supplied by patient; or_____ if revoked in writing by patient; or_____180 days from the date hereof; or_____under the following conditions:_____.*

OTHER CONDITIONS: a COPY of this Authorization or my signature thereon_____may, or _____may not be used with the same effectiveness as an original.

_____
Patient Name (Print)

_____ _____
Person authorized to sign for patient State how authorized

_____ _____
Signature Date

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Information Regarding Cone Beam Radiographic Imaging

Peninsula Orthodontics is pleased to offer the iCat® Cone Beam Computer Assembled Tomography (CBCT) imaging, sometimes called 3-D images or x-rays. Using CBCT means we have the ability to take 3-D images of the teeth, jaws, bones and facial structures. We always employ the ALARA (As Low As Reasonably Achievable) method for determining which type of CT scan to take.

There are 3 types of scans typically taken in our office.

1. Standard Scan at 8.5 seconds exposure time. This CT scan shows most of the head and neck, and is used in adults and older teens. The radiation of this scan has about as much as a film based panoramic image

2. Small Scan at 4.8 seconds exposure time. This CT scan shows the head from the ears forward, between the eyebrows and the chin and is used on children and smaller patients, and it has about ½ the radiation of a film based panoramic image.

3. Dentoalveolar Scan at 4.8 seconds exposure time. This CT scan is our smallest scan and only shows the teeth and their supporting structures. Is used in cases of limited treatment and as a progress scan during treatment. It has the least amount of radiation and is about ¼ of a film based panoramic image.

As orthodontists, our doctors can evaluate the teeth, jaws and the surrounding bone using CBCT scan for orthodontic purposes. Their training and dental license does not provide for evaluating and diagnosing outside those areas. However since CBCT imaging can cover a broader area, we can have your CBCT data read by a radiologist for an additional fee of $85.00 if desired. If you are interested in taking advantage of this service please initial the applicable section and sign the acknowledgement below.

( ) Yes, I want to have my iCat® CBCT scan read by a radiologist. I understand that I am responsible for the additional cost of $85.00, which will be added to my orthodontic fees.

( ) No, I understand the potential benefits of having my CBCT read and interpreted by a radiologist, however I knowingly decline such a referral.

Printed Name of Patient_____ Date_____

Signature of Responsible Party_____

Printed Name of Responsible Party_____

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