Dr. Eldon DeKay PC dba
EAGLE RIVER ORTHODONTICS
16635 Centerfield Dr., Suite 201
Eagle River, Alaska 99577
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Eldon DeKay, D.M.D., M.S.
Robert DeKay, D.M.D.

INFORMED CONSENT

for the Orthodontic Patient

Risks and Limitations of Orthodontic Treatment

Successful orthodontic treatment is a partnership between the orthodontist and the patient. The doctor and staff are dedicated to achieving the best possible result for each patient. As a general rule, informed and cooperative patients can achieve positive orthodontic results. While recognizing the benefits of a beautiful healthy smile, you should also be aware that, as with all healing arts, orthodontic treatment has limitations and potential risks. These are seldom serious enough to indicate that you should not have treatment; however, all patients should seriously consider the option of no orthodontic treatment at all by accepting their present oral condition. Alternatives to orthodontic treatment vary with the individual's specific problem, and prosthetic solutions or limited orthodontic treatment may be considerations. You are encouraged to discuss alternatives with the doctor prior to beginning treatment.

Orthodontics and Dentofacial Orthopedics is the dental specialty that includes the diagnosis, prevention, interception and correction of malocclusion, as well as neuromuscular and skeletal abnormalities of the developing or mature orofacial structures.

An orthodontist is a dental specialist who has completed at least two additional years of graduate training in orthodontics at an accredited program after graduation from dental school.

American Association of Orthodontists

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 made by your family dentist.

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.

Headgears

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 specialists 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. Oftentimes, these conditions occur for no apparent reason and generally cannot be anticipated. Treatment of 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.

Continued on next page

Patient or Parent/Guardian Initials ___________

Patient ______________________ Date __________

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.

Temporary Anchorage Devices

Your treatment may include the use of a temporary anchorage device(s) (i.e. metal screw or plate attached to the bone.) There are specific risks associated with them.

It is possible that the screw(s) could become loose which would require its/their removal and possibly relocation or replacement with a larger screw. The screw and related material may be accidentally swallowed. If the device cannot be stabilized for an adequate length of time, an alternate treatment plan may be necessary.

It is possible that the tissue around the device could become inflamed or infected, or the soft tissue could grow over the device, which could also require its removal, surgical excision of the tissue and/or the use of antibiotics or antimicrobial rinses.

It is possible that the screws could break (i.e. upon insertion or removal.) If this occurs, the broken piece may be left in your mouth or may be surgically removed. This may require referral to another dental specialist.

When inserting the device(s), it is possible to damage the root of a tooth, a nerve, or to perforate the maxillary sinus. Usually these problems are not significant; however, additional dental or medical treatment may be necessary.

Local anesthetic may be used when these devices are inserted or removed, which also has risks. Please advise the doctor placing the device if you have had any difficulties with dental anesthetics in the past.

If any of the complications mentioned above do occur, a referral may be necessary to your family dentist or another dental or medical specialist for further treatment. Fees for these services are not included in the cost for orthodontic treatment.

Patient or Parent/Guardian Initials __________

ACKNOWLEDGEMENT

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 this form with the undersigned orthodontist(s) and have been given the opportunity to ask any questions. I have been asked to make a choice about my treatment. I hereby consent to the treatment proposed and authorize the orthodontist(s) indicated below to provide the treatment. I also authorize the orthodontist(s) to provide my health care information to my other health care providers. I understand that my treatment fee covers only treatment provided by the orthodontist(s), and that treatment provided by other dental or medical professionals is not included in the fee for my orthodontic treatment.

____
Signature of Patient/Parent/Guardian — Date

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Signature of Orthodontist/Group Name — Date

____
Witness — Date

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 above doctor(s) and, where appropriate, staff providing orthodontic treatment prescribed by the above doctor(s) for the above individual. I fully understand all of the risks associated with the treatment.

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I hereby authorize the above doctor(s) to provide other health care providers with information regarding the above individual's orthodontic care as deemed appropriate. I understand that once released, the above doctor(s) and staff has(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 consultations, research, education, publication in professional journals or social media.

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Signature — Date

____
Witness — Date

I have the legal authority to sign this on behalf of

____
Name of Patient

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Relationship to Patient

Notes

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DR. ELDON DEKAY PC dba
EAGLE RIVER ORTHODONTICS

Eldon L. DeKay, D.M.D., M.S *Robert DeKay, D.M.D.*

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ______________________________

Address: ______________________________

Telephone: ______________________ **Email:** ______________________

Patient #: ______________________ **Social Security #:** ______________________

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Persons: Angie Johnson or Dr. Eldon DeKay

Telephone: (907) 694-3555 Fax: (907) 694-3320

Address: 16635 Centerfield Drive Suite 201, Eagle River, AK 99577

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance of this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, ______________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: ______________________ Date: ______________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ______________________

Relationship to Patient: ______________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Dr. Eldon DeKay PC dba

EAGLE RIVER ORTHODONTICS

Eldon DeKay, D.M.D., M.S.

Robert DeKay, D.M.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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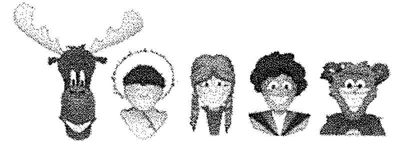
(This Form is educational only, does not constitute legal advice, and covers only federal, not state, law in effect or proposed as of March 27, 2002. Subsequent law changes may require Form revision.)



Welcome to our office!

ADULT REGISTRATION FORM

Eagle River Orthodontics
16635 Centerfield Dr, Suite 201
Eagle River, AK 99577

(Please Print)

Today's date: General Dentist:

Whom may we thank for referring you to our office?

PATIENT INFORMATION

Last name: First: Middle: Sex: M F

Drivers License #: SSN: E-Mail Address:

Home phone: Cell: Birth date: Age:

Mailing Address: City: State: Zip:

Physical Address: City: State: Zip:

Occupation: Employer: Work Phone:

PATIENT'S SIGNIFICANT OTHER

Last Name: First: Middle:

SSN: Birth Date: Home Phone: Cell:

Occupation: Employer: Work Phone: Drivers License#:

ORTHODONTIC INSURANCE INFORMATION

Policy Holder Name: Employer of Policy Holder:

Primary Insurance Company:

Primary Insurance Company Address:

City: State: Zip: Phone #:

Insurance ID: Group #: Policy #:

Policy Holder Name: Employer of Policy Holder:

Secondary Insurance Company:

Secondary Insurance Company Address:

City: State: Zip: Phone #:

Insurance ID: Group #: Policy #:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):

Relationship: Contact #: ( )

I hereby authorize the release of any information to my insurance company or companies including records of examinations, diagnosis, or treatment. This release is solely for the purpose or facilitating the billing and reimbursement, directly to Eagle River Orthodontics, of insurance benefits under which I am entitled. I hereby agree that I am financially responsible for all treatment rendered.

Date:______________________________ Patient Signature:______________________________

Patient's Preferred Name_______________________________ DOB_______________ Age_____

ORTHODONTIC HISTORY

Have you consulted an orthodontist previously? **No** ☐ **Yes** ☐
Have you had prior orthodontic treatment? **No** ☐ **Yes** ☐
What motivated you to seek orthodontic care? _______________________________
What are your expectations from orthodontic treatment? _______________________________

How do you feel about wearing braces? _______________________________

Have any of your friends or members of your family received orthodontic services at our office? **Y** **N**

Name	Relationship	Name	Relationship

MEDICAL HISTORY

Physician's Name _______________________________
Are you in good health? **Y / N**
Check any of the following for which you are now being or have been treated:

a. Rheumatic fever ☐
b. Congenital heart problems ☐
c. Heart murmurs or heart surgeries ☐
d. Artificial joints ☐
e. Any condition that requires prophylaxis (antibiotics) before dental procedures ☐
f. Cardiovascular disease (heart trouble, heart attack, high blood pressure, stroke) ☐
g. Hepatitis ☐
h. Hemophilia ☐
i. Diabetes ☐
j. Epilepsy / Convulsions ☐
k. Asthma ☐
l. AIDS or HIV positive ☐
m. Tuberculosis ☐

* Women - Are you pregnant? **Y / N**

DENTAL HISTORY

General Dentist _______________________________
Date of last check-up and cleaning _______________
Check if you have had any of the following treatment:

1. Periodontal treatment (gum treatment) ☐
   How long ago _______________________________
   Describe the treatment _______________________________
2. Mouthguard or bite splint ☐
3. Surgery to change the bite ☐

Are you aware of any of the following conditions?

1. Sores, lumps or irritated areas in mouth ☐
2. Food catching between teeth ☐
3. Clenching or grinding of teeth ☐
4. Sore or bleeding gums ☐
5. Clicking, popping or grating noise in jaw joint ☐
6. Numbness or tingling in mouth or face ☐

Have you had tonsils / adenoids removed? **Y / N**
Have you ever been a thumb sucker? **Y / N** Mouth breather **Y / N**
Have you been asked to Pre-med for dental appointments? **Y / N**
Have you had an unpleasant experience at a dental office? **Y / N**
If yes, explain: _______________________________

List any other serious recurrent illness (physical or mental) _______________________________

Prescription medications being taken _______________________________

Do you have a Latex Allergy/Sensitivity? **Y / N**
Drug allergies/sensitivity_______________________________

Are you allergic/intolerant to metals? **Y / N** If yes explain_______________________________

The information I have given is correct and will be held in the strictest of confidence.

Signature of Patient _______________________________ **Date** _______________

Updated_______________ _______________ _______________ _______________
Initials/Date **Initials/Date** **Initials/Date** **Initials/Date**