

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.



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 _____

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.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

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

Please Print Name

Signature

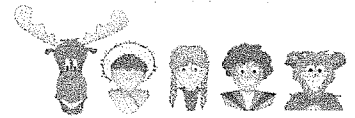
Date

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)

Welcome to our office!



Eagle River Orthodontics
16635 Centerfield Dr, Suite 201

CHILD REGISTRATION FORM

(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
Preferred Name:	SSN:	Birth Date:	Email:
School:	Grade:	Hobbies:	

LEGAL GUARDIAN(S) INFORMATION (CUSTODIAL PARENT RESPONSIBLE FOR ACCOUNT)

Last Name:	First Name:	Middle:	Birth Date:
SSN:	Drivers License #:	Work Phone:	Cell Phone:
Employer:	Occupation:	Email:	
Last Name:	First Name:	Middle:	Birth Date:
SSN:	Drivers License #:	Work Phone:	Cell Phone:
Employer:	Occupation:	Email:	
Mailing Address:	City:	State:	Zip:
Physical Address:	City:	State:	Zip:
Home Phone:			

NON-CUSTODIAL PARENT

Last Name:	First Name:	Middle:	Birth Date:
SSN:	Drivers License #:	Work Phone:	Cell Phone:
Employer:	Occupation:	Email:	
Mailing Address:	City:	State:	Zip:
Physical Address:	City:	State:	Zip:
Home Phone:			

ORTHODONTIC INSURANCE INFORMATION

Policy Holder Name:	Employer of Policy Holder:		
Primary Insurance Company:			
Insurance Company Address:			
City:	State:	Zip:	Phone:
Insurance ID:	Group #:	Policy #:	
Policy Holder Name:	Employer of Policy Holder:		
Secondary Insurance Company:			
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: _____ Responsible Party Signature: _____

Patient's Preferred Name _____ DOB _____ Age _____

Parents' Name(s) _____

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

*For Males: has your voice changed? Y / N

*For Females: has menstruation started? Y / N

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

Prescription medications being taken _____

Drug allergies/sensitivity _____

Does patient have a Latex Allergy/Sensitivity? Y / N

Is patient allergic/intolerant to metals? Y / N If yes explain _____

DENTAL HISTORY

Patient's 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

7. Thumb Sucking

8. Mouth Breather

Has Patient had tonsils/adenoids removed? Y / N

Has patient had an unpleasant experience at a dental office?

If yes explain: _____

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

Signature of Guardian _____ Date _____

Updated _____

Initials/Date

Initials/Date

Initials/Date

Initials/Date