BRUSH HOLLOW Orthodontics

ID# _____

Patient's Name (print) _____ (FIRST) (MIDDLE INITIAL) (LAST)

Address _____ Town _____ Zip Code _____

Male ☐ Female ☐ Telephone: Home _____ Email Address _____

Whom may we thank for referring you to our office _____ School _____ Grade _____

Birth Date _____ (MONTH) (DATE) (YEAR) Birthplace _____ (CITY) (STATE)

Dentist's Name _____ of _____ (CITY) Date of Last Dental Checkup _____

Physician's Name _____ Date of Last Medical Checkup _____

Father's Name _____ Mother's Name _____

Father's Date of Birth _____ Mother's Date of Birth _____

Father's Social Secutiry # _____ Mother's Social Secutiry # _____

Father's Employer & Address _____ Mother's Employer & Address _____

Father's Business Phone _____ Cell _____ Mother's Business Phone _____ Cell _____

Parents Marital Status: Married ( ) Divorced ( ) Widowed ( ) Separated ( ) Single ( )

Other Children's Names and Ages _____

Are any family members currently in treatment? _____ **If so, who?** _____

Currently wearing braces? _____

Wearing Retainers? _____ **Has an appliance?** _____ **Invisalign?** _____

Waiting to begin treatment? _____

1. WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS TO ACCOMPLISH FOR YOUR CHILD?

_____

2. Is you child in good health? _____ 3. Does your child have regular medical examinations? _____

4. Has your child ever had any of the following (please Check)

Anemia _____	Hepatitis _____	Liver or kidney disease _____	**Allergies to any Drugs** _____
Diabetes _____	Hives _____	Jaw pain _____	Mitral valve prolapse _____
Asthma _____	Jaundice _____	Rheumatic fever _____	Handicaps or disabilities _____
Epilepsy _____	Pneumonia _____	Blood disorders _____	HIV / AIDS ADD / ADHD ____
Hay fever _____	Heart disease _____	Chronic headaches _____	Cancer _____
Hemophilia _____	Migraines _____	Fainting _____	Osteoporosis _____

5. Does your child require pre-medication for any condition? _____ If so, for what? _____

6. Is there anything else we should know about your child's general health? Such as allergies to medications, food, Latex, etc _____

7. Has your child ever had any injuries to the face, mouth, teeth, or chin? If yes, please _____

8. Is your child a mouth-breather or thumb sucker? if yes, please explain _____

9. Is there a hereditary background that might contribute to your child's dental problem _____

10. Has your child ever had any pain / tenderness in their jaw joint (TMJ)? _____

11. Other Remarks _____

12. Please indicate any medications that your child is currently taking _____

13. Do you have Insurance? _____ Name of Insurance Co. _____

REVIEWED BY DR. _____ DATE _____

UPDATED BY _____ DATE _____

_____ (Your signature) (Today's Date)

EDITED JULY 2021

BRUSH HOLLOW Orthodontics

DENTAL INSURANCE INFORMATION
(PLEASE PRESENT YOUR DENTAL INSURANCE CARD)

PATIENT NAME: _____ DOB: _____

PRIMARY DENTAL INSURANCE COMPANY NAME: _____

DENTAL INSURANCE COMPANY
ADDRESS _____

DENTAL INSURANCE COMPANY PHONE NUMBER: _____

EMPLOYER: _____ EMPLOYER ADDRESS: _____

NAME OF POLICY HOLDER: _____ SS# _____

HOME ADDRESS: _____

INSURED'S ID # _____ POLICY HOLDER'S DATE OF BIRTH: _____

GROUP # _____ RELATIONSHIP TO INSURED: _____

SECONDARY INSURANCE COMPANY: _____

DENTAL INSURANCE COMPANY
ADDRESS: _____

DENTAL INSURANCE COMPANY PHONE NUMBER: _____

EMPLOYER: _____ EMPLOYER ADDRESS: _____

NAME OF POLICY HOLDER: _____ SS# _____

HOME ADDRESS: _____

INSURED'S ID # _____ POLICY HOLDER'S DATE OF BIRTH: _____

GROUP # _____ RELATIONSHIP TO INSURED: _____

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agencies for the purpose of obtaining payment for services and determining dental insurance benefits payable for related services.

_____ _____
Signature Date

BRUSH HOLLOW Orthodontics

Thank you for choosing our office for Orthodontic Care.

Successful orthodontic treatment is a partnership between the doctor and an informed, cooperative patient. Thus, the following information is routinely provided to anyone considering orthodontic treatment.

While recognizing the benefits of a pleasing smile and well-aligned, healthy teeth, you should be aware that orthodontic treatment, like any type of health care, has some inherent risks and limitations. These are seldom enough to advise against treatment, but should be considered when making the decision to wear orthodontic appliances. Please feel free to ask any questions about this before treatment.

One of the most important areas of patient cooperation is oral hygiene. Excellent oral hygiene and plaque removal is a must! Sugars and between-meal snacks should be eliminated. If patients do not brush their teeth properly and thoroughly during the treatment period, the results could be decalcification (permanent markings), tooth decay, or gum disease. Additionally, to help guard against tooth decay, the patient should rinse with a fluoride rinse daily.

A tooth that has been traumatized from a deep filling or even a minor blow may lose its vitality or turn dark over a period of time with or without orthodontic treatment. An undetected non-vital tooth may flare up during orthodontic treatment, requiring root canal treatment to maintain it.

In a small percentage of patients, possibly because of an increased susceptibility of the patient, the roots of the teeth become shortened somewhat during treatment. This is called "root resorption", and under healthy circumstances causes no disadvantage. However, in the event of gum disease in later life, the root resorption could reduce the longevity of the affected teeth. It should be noted that not all root resorption arises from orthodontic treatment. Trauma, impaction, hormonal disorders, or unknown reasons can also cause root resorption.

In attempting to move impacted or partially erupted teeth, especially canines, difficulties are sometimes encountered which may lead to loss of the tooth, or the adjacent tooth, or periodontal problems requiring further treatment. These will be explained to you in advance should they apply to your treatment.

Possible problems (including pain and clicking) of the temporomandibular joints (TMJ or jaw joints) may exist prior to or occur during orthodontic treatment. Existing improper tooth position of a poor bite can be a factor in this condition. Tooth alignment and bite correction will often improve jaw joint pain or problems, but not in all cases. Also, stress and tension appear to play a role in the frequency and severity of joint and muscle problems.

Occasionally a child, whose jaws have grown normally, and in average proportions, may not continue to do so. If growth becomes disproportionate, the jaw relations can be affected and original treatment objectives may have to be compromised. Skeletal growth disharmony is a biological process and is beyond the orthodontist's control.

If headgear is required, instructions must be followed carefully. Horseplay with headgear is dangerous. If a headgear is pulled outward while the elastic force is still attached, it will act like a sling shot and snap back, poking tissue such as gums, lips ,cheeks and even eyes. Always release the elastic force before removing headgear. To prevent accidents, headgear should not be worn during contact sports of any kind.

Teeth have a tendency to want to revert to their original positions after orthodontic treatment. This is called relapse. The more severe the original malocclusion, the greater the tendency towards relapse. To counter this, positioners and retainers are worn to support and hold teeth in their new positions. This is called the retention period. Full cooperation during retention is vital if teeth are to remain in their new positions. When retention is discontinued, some relapse is still possible.

Shifting of the teeth with age even occurs in people who have not had orthodontic treatment. Therefore, slight irregularities, particularly of the lower front teeth, may sometimes have to be accepted as the best possible result.

The total treatment time can be delayed beyond our estimate. Lack of facial growth, poor motivation, poor cooperation in wearing elastics, headgear, or other removable appliances, poor oral hygiene, broken appliances, improper diet, missed appointments, slow eruption of teeth, or tardiness could lengthen treatment time and affect the quality of the results.

While we have listed a number of negatives, fortunately each patient is an individual, and these general statements do not apply in every case. Orthodontic treatment is a team effort and involves cooperation between the patient, their parents, the orthodontist and his staff. The better the cooperation, the less likelihood there will be for problems or limitations with treatment. It is very important to us that we become good friends, because the orthodontic experience lasts for years, not months.

Thank you for reading the above material, and we thank you in advance for your cooperation.

I HAVE READ AND UNDERSTAND THE ABOVE MATERIAL AND CONSENT TO ORTHODONTIC TREATMENT

_____ _____ _____ _____

Patient or Responsible party *date* *Witness* *date*

BRUSH HOLLOW Orthodontics

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 attemped to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but

( ) Individual refused to sign

( ) Communications barriers prohibited obtaining the acknoledgement

( ) An emergency situation prevented us from obtaining acknowledgement

( ) Other (Please Specify)

_____

_____

_____

BRUSH HOLLOW Orthodontics

Photo Consent Form

Brush Hollow Orthodontics would like your permission to use images taken of the patient (yourself or your child) for educational training purposes demonstrated to students, and/or colleagues. These images may also be used to showcase amazing before and after smile transformations on social media platforms.

Declaration

☐ I grant permission for photographs of me/my child to be used for educational purposes and transformation features as indicated above.

☐ I **DO NOT** grant permission for photographs of me/my child to be used in any of the formats indicated above.

_____

Name of Patient (Print)

_____

Name of Parent/Guardian (if minor)

_____ _____

Signature Date

For examples of the transformation features we do of our patients please visit our Facebook or Instagram pages.