WELCOME TO OUR PRACTICE!

We look forward to your first orthodontic visit on _____ at _____. Orthodontics is the branch of dentistry which deals with the straightening of the teeth and alignment of the jaws in order to improve the function, health and appearance of the mouth and face.

Your initial appointment will consist of an examination which allows us to get acquainted and determine the basic nature of the orthodontic malocclusion and need for treatment. If treatment is indicated, diagnostic records will be recommended. These records include: photographs of the mouth and face; a cephalometric (head) x-ray showing the relative positions of the teeth and supporting structures; a panoramic (full mouth) x-ray; and an accurate set of plaster models of the patient's teeth and surrounding structures.

During this visit, any general questions you may have about orthodontic treatment will be discussed. Please assist us by bringing all necessary insurance information and taking time to review your policy benefits and limitations. The patient history questionnaires and privacy consent included in this package should be completed and brought in as well.

Following a thorough study of the diagnostic data, our finds and recommendations for treatment will be presented at a second consultation appointment. We will review with you the nature and extent of the orthodontic problem, treatment objectives, methods of correcting the problem and estimated duration of treatment. All specific questions you may have will be answered. If possible, it is desirable that both parents of a minor patient be present for this appointment.

We look forward to working with you toward our goal of a beautiful smile!

Moshe Stern, D.D.S., M.S. | 2730 Hanover Pike, Manchester, MD 21102 | Phone: 410-374-4882 | Fax: 410-374-0702
www.PremierDentalCare.net/Services/Orthodontics

This initial consultation appointment is to determine whether or not orthodontic treatment is needed, at what age level would be most advantageous, and to give you some insight into orthodontic treatment. If treatment is required, this appointment may also be for the purpose of taking records consisting of x-rays, photographs, and study models. A second appointment will be necessary to confer with the parents of the child, or with the adult patient. At this conference appointment, all aspects of the treatment are thoroughly discussed.

If treatment is not indicated at this time, periodic observation appointments may be necessary to assess the proper timing for treatment.

PATIENT INFORMATION

Date_____ Sex ❒ M ❒ F Home Phone_____ Contact Email_____

Patient's Full Name_____ Preferred Name_____

Age_____ Date of Birth_____ Sports/Hobbies_____

Home Address (street)_____ (city)_____ (state)_____ (zip)_____

Relatives of Friends in Treatment_____

Family Dentist_____ Referred By_____

Family Physician_____ Phone_____ Health Status_____

Allergies_____

Medications or Drugs Being Taken_____

In Case of Emergency, Name and Phone Number of Nearest Friend of Relative_____

_____

Additional Comments_____

Need for Antibiotic Prophylaxis for Heart Condition_____

Father's Name_____ Mother's Name_____

Father's Business Phone_____ Occupation_____ S.S.#_____

Place of Employment_____

Mother's Business Phone_____ Occupation_____ S.S.#_____

Place of Employment_____

RESPONSIBLE PARTY INFORMATION

Name_____ Date of Birth _____

Relationship to Patient_____ S.S.#_____

Home Address_____ Home Phone_____

Place of Employment_____ Business Phone_____

Is Patient Covered by Orthodontic Insurance?_____

Name of Insurance Company_____

PLEASE READ: *In the event that an orthodontic problem exists, you will be counseled to have orthodontic records taken. These records usually consist of study model, tooth and facial x-rays, photographs, and diagnostic measurements and tracing. The doctors use this information to diagnose the extent of the problem and to formulate a treatment plan.* ***Our fee for treatment includes these records. However, should you elect not to pursue treatment, you will be responsible for the cost of these records, as well as any collection fees incurred. Your signature below indications that you are aware of this office policy.***

_____ _____

Signature (Parent/Guardian if patient is a minor) *Please print name*

Moshe Stern, D.D.S., M.S. | 2730 Hanover Pike, Manchester, MD 21102 | Phone: 410-374-4882 | Fax: 410-374-0702

www.PremierDentalCare.net/Services/Orthodontics

DENTAL INSURANCE CARRIER

** We strongly suggest that you contact your insurance company to familiarize yourself with your benefits prior to your first orthodontic appointment.*

Primary Insurance Carrier Name_____ Phone_____

Insurance Carrier Address_____

Employer Name and Phone_____

Name of Insured Party_____ S.S.#_____ Birth Date_____

Secondary Insurance Carrier Name_____ Phone_____

Insurance Carrier Address_____

Employer Name and Phone_____

Name of Insured Party_____ S.S.#_____ Birth Date_____

DENTAL HISTORY

Date of most recent dental examination_____

Reason for this Orthodontic Appointment_____

Please circle Yes or No. Questions pertain to the patient being examined.

Yes No Does patient follow directions?
Yes No Does patient have learning disabilities or need extra help with instructions?
Yes No Is patient sensitive, self-conscious?
Yes No Any problems with previous dental treatment?_____
Yes No Ever been treated for "TMJ" problems (jaw joint and facial muscle pain)?
Yes No Previous orthodontic consultation or treatment?
Yes No Periodontal surgery or treatment?
Yes No Clicking or soreness when mouth is opened?
Yes No Oral surgery?
Yes No Teeth extracted or missing?
Yes No Problems with bleeding or gum healing after surgery?
Yes No Injuries to the face, mouth or teeth?
Yes No Grinding/clenching teeth?
Yes No Sensitivity to heat, cold or sweets?
Yes No Fluoride treatments?
Yes No Speech therapy?
Yes No Mouth breathing habit, snoring, difficulty in breathing?
Yes No Difficulty in chewing or jaw opening?
Yes No Jaw fractures, cysts, mouth infections?
Yes No Frequent canker sores or cold sores?
Yes No Thumb or finger sucking habit? Until_____

Other_____

_____

Please complete other side

Moshe Stern, D.D.S., M.S. | 2730 Hanover Pike, Manchester, MD 21102 | Phone: 410-374-4882 | Fax: 410-374-0702
www.PremierDentalCare.net/Services/Orthodontics

DENTAL • CARE
Premier
EXCELLENCE IN AESTHETIC & GENERAL DENTISTRY

MEDICAL HISTORY

For the following questions circle Yes or No. The answers are for the office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

Yes No Birth defects or hereditary problems?
Yes No Bone fractures, any major accidents?
Yes No Is patient pregnant?
Yes No Rheumatoid or arthritic conditions?
Yes No Endocrine or thyroid problems?
Yes No Kidney problems?
Yes No Diabetes?
Yes No Cancer or been treated for a tumor?
Yes No Stomach ulcer or hyperacidity?
Yes No Polio, mono, tuberculosis, pneumonia?
Yes No Problems of the immune system?
Yes No AIDS or HIV positive?
Yes No Hepatitis, jaundice or liver problems?
Yes No Fainting spells, seizures, epilepsy or neurologic problems?
Yes No Mental health or behavioral problems?
Yes No Vision, hearing, tasting, or speech difficulties?
Yes No Loss of weight recently, poor appetite?
Yes No Excessive bleeding, black and blue tendency, anemia or bleeding disorder?
Yes No High or low blood pressure?
Yes No Tire easily?
Yes No Chest pain, shortness or breath or swelling ankles?
Yes No Cardiovascular problem (heart trouble, heart attack, angina)?
Yes No Skin disorder?
Yes No Frequent headaches, colds or sore throats?
Yes No Eye, ear, nose, throat, sinus condition?
Yes No Hayfever, hives?
Yes No Asthma?
Yes No Tonsil or adenoid conditions?
Yes No Allergies or drug reactions?
Yes No Are you taking medication or non-prescription medicine?_____
Yes No Does the patient currently have or ever had a substance abuse problem?
Yes No Operations, surgeries?_____
Yes No Hospitalization for_____
Yes No Other physical problems or symptoms?_____
Yes No Being treated by another health care professional for_____

Please describe any other disease, condition, medical problems or other information that we should be aware of _____

_____

I have read and understand the above questions, and I certify that the above information I have give is true and complete to the best of my knowledge. I will not hold this orthodontist or any member of his staff responsible for any errors or omissions that I have made in completion or this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

_____ _____
Signature (Parent/Guardian if patient is a minor) *Date*

Please return these forms to the office at your first orthodontic visit.

Moshe Stern, D.D.S., M.S. | 2730 Hanover Pike, Manchester, MD 21102 | Phone: 410-374-4882 | Fax: 410-374-0702
www.PremierDentalCare.net/Services/Orthodontics

INFORMED CONSENT PERTINENT TO PATIENTS UNDERGOING ORTHODONTIC TREATMENT

As a rule, excellent orthodontic results can be achieved with informed and cooperative patients. Thus, the following information is routinely supplied to anyone considering or undergoing orthodontic treatment in our office. While recognizing the benefits of a pleasing smile and healthy teeth, you should also be aware that orthodontic treatment, like any treatment of the body, has some inherent risks and limitations. These are seldom enough to contraindicate treatment, but should be considered in making the decision to wear orthodontic appliances.

Throughout life tooth position is constantly changing. This is true with all individuals regardless or whether they have had orthodontic treatment or not. Post-orthodontic patients are subject to the same subtle changes that occur in non-orthodontic patients. In the late teens or early twenties our patients may notice slight irregularities developing in their front teeth. This is particularly true if their teeth were extremely crowded prior to treatment. Retainer wear is critical to minimize tooth shifting.

Decalcification (permanent markings), decay, or gum disease can occur if patients do not brush their teeth properly and thoroughly during the treatment period. Excellent oral hygiene and plaque removal is a must. Sugars and between meal snacks should be eliminated. Routine recall appointments with your general dentist must be kept.

On rare occasions the nerve of a tooth may become non-vital. A tooth that has been traumatized from a deep filling or even a minor blow can die over a long period of time with or without orthodontic treatment. An undetected non-vital tooth may flare up during orthodontic movement requiring endodontic (root canal) treatment to maintain it.

In some cases, the root ends of the teeth are shortened during treatment. This is called root resorption. Under healthy circumstances the shortened roots are no disadvantage. However, in the event of gum disease later in life, root resorption could reduce the longevity of affect teeth. It should be noted that not all root resorption arises from orthodontic treatment. Trauma, cuts, impaction, endocrine disorders and idiopathic reasons can also cause root resorption.

There is also a risk that problems may occur in the temporomandibular joints (TMJ). Although this is rare, it is a possibility. Tooth alignment or bite correction can improve tooth related causes of TMJ pain but not in all cases. Tension appears to play a role in the frequency and severity of joint paints.

Occasionally a person who has grown normally and in average proportion may not continue to do so. If growth becomes disproportionate, the jaw relation can be affected and original treatment objectives may have to be compromises. Skeletal growth disharmony is a biological process beyond the orthodontists control.

Perfection is our goal. However, in dealing with human beings and problems of growth and development, genetics and patient cooperation, achieving perfection is not always possible. Often a functionally and esthetically adequate result must be accepted.

The total time for treatment can be delayed beyond our estimate. Lack of facial growth, poor elastic wear or headgear cooperation, broken appliances and missed appointments are all important factors which could lengthen treatment time and affect the quality of the result.

Headgear instructions must be followed carefully. A headgear that is pulled outward while the elastic force is attached can snap back and poke into the face or eyes. Be sure to release the elastic force before removing the headgear from the teeth.

I have read and understand this letter of information.

_____ _____

Signature *Date*

Moshe Stern, D.D.S., M.S. | 2730 Hanover Pike, Manchester, MD 21102 | Phone: 410-374-4882 | Fax: 410-374-0702

www.PremierDentalCare.net/Services/Orthodontics

PRIVACY NOTICE FOR PREMIER DENTAL CARE AND DR. MOSHE STERN

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. YOUR PRIVACY IS IMPORTANT TO US.

Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax, email address, home address, social security numbers, and demographics data) may be used or disclosed by us in one or more of the following aspects.

- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery, etc.);
- To third party payers (i.e., insurance companies, employers with direct reimbursement, administrators or flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates or payment, etc.);
- To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in treatment;
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;
- To your family and close friends involved in your treatment, and/or,
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and serves that may be of interest to you.

And other uses or disclosures of your protected health information will be made only after obtaining written authorization, which you have the right to revoke.

_____

Signature (Parent/Guardian if patient is a minor)