Oasis Orthodontics

Scott P. Day, DMD, MS

WELCOME TO OUR OFFICE

Would you please take a few minutes and complete our Patient History Form. Please be specific and complete with your answers, as this will aid us in providing the best care to you and your family. Thank you!

Patient's Last Name: _____ First Name: _____ Nickname: _____
Patient's Address: _____
City: _____ State: _____ Zip Code: _____
Date of Birth: _____ Age: _____ Male: _____ Female: _____ Home Phone: _____
Patient attends school at: _____ Other family members treated here: _____

Mother's Name: _____ Home Phone: _____ Cell # _____
Address: _____ City: _____ Zip Code: _____
E-Mail address: _____

Father's Name: _____ Home Phone: _____ Cell # _____
Address: _____ City: _____ Zip Code: _____
E-Mail address: _____

Patient's Dentist: _____ Phone # _____ Last visit: _____
Physician's Name: _____ Phone # _____ Last Visit: _____

Do you have Orthodontic Coverage? _____ Do you know your benefits? _____
If you would like our office to verify and/ or file for orthodontic coverage, all information below must be completely filled out (if applicable).

1) Policy Holder's Name: _____ S.S.N.: _____ Group # _____
Date of Birth: _____ Employed by: _____ Policy I.D.: _____
Insurance Company Name: _____ (Benefits) Phone Number: _____
Insurance Company Address: _____ City: _____ Zip Code: _____

2) Policy Holder's Name: _____ S.S.N.: _____ Group # _____
Date of Birth: _____ Employed by: _____ Policy I.D.: _____
Insurance Company Name: _____ (Benefits) Phone Number: _____
Insurance Company Address: _____ City: _____ Zip Code: _____

For the following questions mark yes, no, or don't know/understand (dk/u). The answers are for our records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

Patient Profile

☐ yes ☐ no ☐ dn/u Does patient follow directions well?
☐ yes ☐ no ☐ dn/u Does patient have learning disabilities?
☐ yes ☐ no ☐ dn/u Does patient brush his/her teeth conscientiously?
☐ yes ☐ no ☐ dn/u Is patient sensitive or self-conscious about teeth?

Medical History

☐ yes ☐ no ☐ dn/u Birth defects or heredity problems?
☐ yes ☐ no ☐ dn/u Diabetes?
☐ yes ☐ no ☐ dn/u Stomach ulcer or hyperactivity?
☐ yes ☐ no ☐ dn/u AIDS or HIV positive?
☐ yes ☐ no ☐ dn/u Fainting spells, seizures?
☐ yes ☐ no ☐ dn/u Vision, hearing, tasting or speech difficulties?
☐ yes ☐ no ☐ dn/u High or low blood pressure?
☐ yes ☐ no ☐ dn/u ANY cardiovascular problems (murmur, defects)?
☐ yes ☐ no ☐ dn/u Hayfever, asthma, sinus trouble or hives?
☐ yes ☐ no ☐ dn/u Does the patient chew or smoke tobacco?
☐ yes ☐ no ☐ dn/u Rheumatoid or arthritic conditions?
☐ yes ☐ no ☐ dn/u Cancer, tumor, radiation treatment or chemotherapy?
☐ yes ☐ no ☐ dn/u Problems of the immune system?
☐ yes ☐ no ☐ dn/u Hepatitis, jaundice or liver problem?
☐ yes ☐ no ☐ dn/u Epilepsy or neurological problem?
☐ yes ☐ no ☐ dn/u History of eating disorder (anorexia, bulimia)?
☐ yes ☐ no ☐ dn/u Chest pain, shortness of breath or swelling ankles?
☐ yes ☐ no ☐ dn/u Frequent headaches, colds or sore throats?
☐ yes ☐ no ☐ dn/u Tonsil or adenoid conditions?
☐ yes ☐ no ☐ dn/u Has the patient ever had a substance abuse problem?

Are there any Medical conditions we should be aware of? _____

Member American Association of Orthodontists

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DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

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Is patient taking medication, nutrient supplements, herbal medications or non prescription medicine? _____ YES _____ NO
Please list them _____

Allergies or reactions to any of the following:

☐ yes ☐ no ☐ dn/u Local anesthetics (Novocaine or Lidocaine)
☐ yes ☐ no ☐ dn/u Ibuprofen (Motril, Advil)
☐ yes ☐ no ☐ dn/u Sulfa drugs
☐ yes ☐ no ☐ dn/u Metals(jewelry, clothing snaps)
☐ yes ☐ no ☐ dn/u Vinyl
☐ yes ☐ no ☐ dn/u Animals
☐ yes ☐ no ☐ dn/u Acrylic
☐ yes ☐ no ☐ dn/u Aspirin
☐ yes ☐ no ☐ dn/u Penicillin or other antibiotics
☐ yes ☐ no ☐ dn/u Codeine or other narcotics
☐ yes ☐ no ☐ dn/u Latex (gloves, balloons)
☐ yes ☐ no ☐ dn/u Foods (specify) _____
☐ yes ☐ no ☐ dn/u Other substances (specify) _____

Dental History

Now or in the past , has the patient had:

☐ yes ☐ no ☐ dn/u Baby teeth removed that were not loose?
☐ yes ☐ no ☐ dn/u Congenitally missing teeth?
☐ yes ☐ no ☐ dn/u Chipped or injured baby teeth?
☐ yes ☐ no ☐ dn/u Jaw fractures, cysts or mouth infections?
☐ yes ☐ no ☐ dn/u Bleeding gums, bad taste or mouth odor?
☐ yes ☐ no ☐ dn/u Food impaction between teeth?
☐ yes ☐ no ☐ dn/u Abnormal swallowing habit (tongue thrusting)?
☐ yes ☐ no ☐ dn/u Mouth breathing, snoring or difficulty breathing?
☐ yes ☐ no ☐ dn/u Any pain in jaw or ringing in ears?
☐ yes ☐ no ☐ dn/u Difficulty in chewing or jaw opening?
☐ yes ☐ no ☐ dn/u Any teeth irritating cheek, lip, tongue or palate?
☐ yes ☐ no ☐ dn/u Frequent canker sores or cold sores?
☐ yes ☐ no ☐ dn/u Any relative with similar tooth or jaw relation?
☐ yes ☐ no ☐ dn/u Ever had a prior orthodontic examination?
☐ yes ☐ no ☐ dn/u Would you object to wearing orthodontic appliances (braces) should they be indicated?
☐ yes ☐ no ☐ dn/u Any serious trouble associated with any previous dental treatment?
☐ yes ☐ no ☐ dn/u Permanent or "extra" teeth removed?
☐ yes ☐ no ☐ dn/u Chipped or injured permanent teeth?
☐ yes ☐ no ☐ dn/u Teeth sensitive to hot or cold: teeth throb or ache?
☐ yes ☐ no ☐ dn/u "Dead teeth" or root canal treated teeth?
☐ yes ☐ no ☐ dn/u Periodontal "gum problems"?
☐ yes ☐ no ☐ dn/u Thumb, finger or sucking habit? To what age?____
☐ yes ☐ no ☐ dn/u History of speech problems?
☐ yes ☐ no ☐ dn/u Tooth grinding or jaw clenching?
☐ yes ☐ no ☐ dn/u Any pain in the muscles around the ears or face?
☐ yes ☐ no ☐ dn/u Aware of loose, broken or missing restorations?
☐ yes ☐ no ☐ dn/u Concerned about spaced, crooked or protruding teet
☐ yes ☐ no ☐ dn/u Taking any forms of fluoride?
☐ yes ☐ no ☐ dn/u Had periodontal (gum) treatment?
☐ yes ☐ no ☐ dn/u Been under another dentist's care?

GIRLS ONLY

☐ yes ☐ no ☐ dn/u Has the patient started her monthly periods?
☐ yes ☐ no ☐ dn/u Is the patient pregnant?

Family Medical History

Do the patient's parents or siblings have any of the following health problems? If so, Please explain.

Bleeding disorders _____
Diabetes _____
Arthritis _____
Metabolic disturbances _____
Severe allergies _____
Unusual dental problems _____
Jaw size imbalance _____
Any other family medical conditions we should know about? _____

How often does your child brush: _____ Floss: _____
What is your primary concern? _____

I have read and understand the above questions. I will not hold Dr. Scott Day or any member of his staff responsible for any errors c omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/ dental status, I will so inform the practice.

Signed: _____ Date: _____
(Parent or Guardian)

Signed: _____ Date: _____
(Dental Staff Member)

Oasis Orthodontics
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INFORMED CONSENT IN ORTHODONTICS

Dear Parent/Patient,

As a rule, excellent orthodontic results can be achieved with informed and cooperative patients. Thus, the following information is routinely supplied to anyone considering 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.

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 aesthetically adequate result must be accepted.

Throughout life, tooth position is constantly changing. This is true with all individuals regardless of 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.

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.

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 orthodontics 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 resorption. Under healthy circumstances the shortened roots are no disadvantage. However, in the event of gum disease in later life, root resorption could reduce the longevity of the affected teeth. It should be noted that not all root resorption arises from orthodontic treatment. Trauma, cuts, impaction, endocrine disorders, or idiopathic reason can also cause root resorption.

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

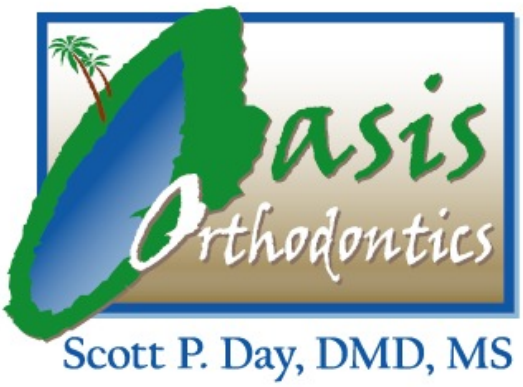
Occasionally, a person who has grown normally and in the average proportion may not continue to do so. If growth becomes disproportionate, the jaw relation can be effected and original treatment objectives may have to be compromised. Skeletal growth disharmony is a biological process beyond the orthodontist's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

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

I have read and fully understand the above.

_____ _____

Signature of Parent/Guardian, or Patient Date



Consent for Diagnostic Record

I, _____, give my consent for __ myself __son __daughter
(print name)

_____, to have diagnostic x-rays, impressions, and photographs
(print name)

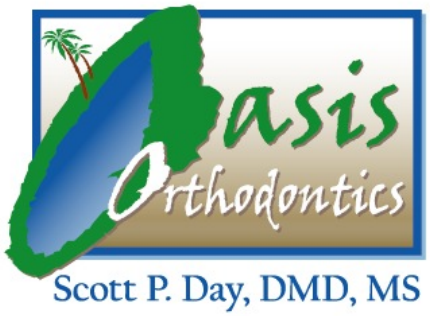
taken.

I have been given the explanation of each procedure that is to take place. I understand that the forenamed procedure is necessary for the doctor to make a complete diagnosis.

These records may be used in board recertification, educational purposes such as professional case presentations, or office promotional material. _____ (initial)

_____ _____
Signature of patient **date**

_____ _____
Signature of parent or legal guardian **date**



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PRIVATE HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU MAY ACCESS THIS INFORMATION

Our Healthcare Practice takes patient privacy matters seriously. We work hard to meet and exceed all existing rules and regulations and will work to keep you informed regarding our office policies and your personal rights regarding privacy.

We are required by federal and state law to maintain the privacy of your health information. We are also required to give you this NOTICE about our privacy practices, or duties, and your rights concerning your personal health information. We must follow the privacy practices described in this NOTICE while it is in effect. This Notice takes effect on April 14, 2003, and will remain in effect until we replace it, at which time we will issue a new Notice to Patients indicating a new activation date. You may request a copy of our Notice at any time, and may request additional copies, as needed by contacting our office.

How We Disclose Health Information:

Specialist Referrals:
We use and disclose health information about you for treatment within our practice, for general healthcare operations, and payment collection. That means your information is available to our immediate staff, and to other practitioners who we may refer you to for additional treatment. This includes, but is not limited to, other healthcare specialists such as surgeons, laboratories and the like. We will exercise our judgment in only distributing the minimum necessary information needed when sending health information to any outside Associates.

General Business Operations:
Your information may be reviewed in the course of general healthcare operations for activities such as conducting quality reviews, assessing practitioner performance, evaluation of business costs, conducting training programs, licensing, accreditation, and certain certification activities, and other business related evaluations help us in improving our delivery of healthcare to our parents.

Payment and Collection:
Your health information will be sent to third party payers for insurance collection and, when applicable, to collection agencies for assistance to us receiving payment for services rendered. Additionally information may be used from time to time as necessary to secure payment for services. We will use our professional judgment and experience with common practice to make decisions on what information to disclose to secure payment.

Family, Friends, Personal Representatives and Others:
We may disclose your health information to a family member, friend, or other persons to the extent necessary to help with your healthcare or with payment for you healthcare. You may however request we not disclose to anyone other than yourself, of which we will abide. An example where we might disclose to a family member or friend might be when someone drives you to the practice and we are reporting on progress and time remaining before completion, or where a family member desires to pick up a prescription or x-rays on your behalf. We will use our professional judgment and experience with common practice when disclosing your health information that it is directly relevant to the person's involvement in your healthcare. We may disclose health information to others who may be involved in your healthcare and are trying to ascertain your general condition, your current location, or learn of your death.

Marketing Health-Related Services:
We will not use your health information for marketing communications without your written authorization. Under federal privacy rules we may send you update information about our practice or healthcare system, send you information regarding programs and products we offer to further enhance your care and treatment, send reminder notices for appointments, and offer small nominal gifts from time to time, such as tooth brushes, which is not considered marketing. We will never provide your name to an outside organization for marketing.

Our Business Associates:
We require all of our Business Associates to sign a contract specifying they too, are strictly following patient privacy rules and regulations. We will act swiftly and decisively if we find any violate provision of their contract.

When the Law Requires Us to Disclose:
We may disclose your health information to government agencies or other, as required by law. Examples of this include, but are not limited to, law enforcement, required state agency reporting, or coroners seeking to confirm identity. Additionally we disclose to military authorities for purposes such as national security.

Abuse and Neglect:
We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or are the victim of possible other crimes. We disclose to the extent necessary to avert further harm to you or others.

PATIENT RIGHTS

Access to Records:
You have a right to look at copies of your health information, with limited exceptions. You may request photocopies and copies of x-rays. We will use the format you request, unless we are unable to practically do so. You must make your request to access health information in writing to our practice. We can provide you with a form to do this, or you may do it by writing a letter specifying exactly what you want to view. If we provide photocopies we will charge you a set amount for each page copied. If you wish to receive x-ray duplicates we will charge you a set fee per film copied. Check with the office for the current fee schedule. If you request an alternate format we will charge you per the expenses we incur to satisfy your request. You may prefer to ask for a summary rather than receive all of the pages in your file. We can prepare a summary depending on what you are seeking to obtain. The fee for summation will vary depending on time to compile. The hourly rate for summation is also on our current fee schedule.

We have up to 30 days (and sometimes longer) to respond, depending on what is required to meet your request. Specifics will be provided upon request.

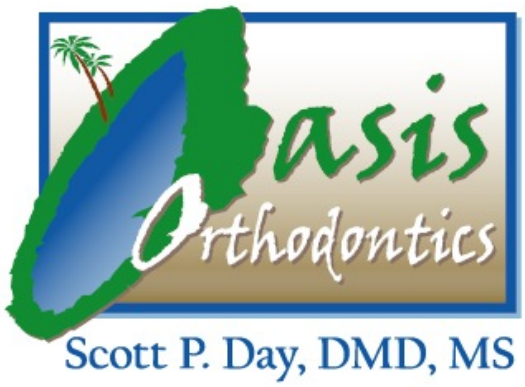
List of Disclosures:
You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and a few other activities as specified by law, for the last six years, but not before April 14, 2003. If you request this list more than once in a 12 month period we will charge you a reasonable cost based fee for responding to the additional requests. Fees will be disclosed prior to actions being taken.

Restrictions:
You have the right to place additional restrictions on our use or disclosure of your health information. We are not required to agree to these restrictions, however, if we do agree, we will abide by our agreement, except in certain emergency situations.

Communications to You:
You may request we communicate with you about your health information by alternative means or to alternative locations, when you make the request in writing. You must specify the alternative means or location and provide satisfactory explanation how payments will be made under the alternative means or location.

Amendment of Your Records:
You have the right to request we amend your health information when requested in writing. We may deny your request however we will note in your records your request to amend and reason. We cannot delete anything from the formal record but we can add addendums to the record that may be able to meet your amendment request.

Electronic Notice of this Information:
If you received this information electronically (via email), you are entitled to receive this in written hard copy form.



NOTICE OF PRIVACY PRACTICES

Patient Acknowledgment of Receipt

This Healthcare Practice recognizes that every patient has the Right of Privacy concerning their personal health information. We make every effort to protect and preserve patient records in a manner that secures this information.

By signing this Acknowledgment:

You are only confirming that you have been offered a copy of our Privacy Practices.

You do not give up any of your Rights and you may choose at some point in the future to provide more specific instructions for us to follow regarding your personal health information.

I have been offered a copy of this Office's Notice of Privacy Practices:

Print Patient Name: _____

Sign your name: _____

Date: _____