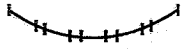


SAWRIE
ORTHODONTICS



DANIEL C. SAWRIE D.D.S., M.S.

Daniel C. Sawrie D.D.S., M.S.

1612 Gunbarrel Road, Suite 100, Chattanooga, TN 37421

1229 Taft Highway, Signal Mountain, TN 37377

phone: 423.624.8217 fax: 423.629.5170

www.sawrieortho.com

PATIENT INFORMATION

Date _____	Age _____	Birth Date _____	Sex _____
Patient's Name			
Last _____	First _____	MI _____	Preferred Name _____
Home Address			
Street _____	City _____	State _____	ZIP _____
Home Phone _____			
Driver's License # (if applicable) _____		Social Security # _____	
Whom may we thank for recommending our services? _____			
Names and ages of children in family _____			
Have any been seen in our office? <input type="checkbox"/> No <input type="checkbox"/> Yes: _____			

RESPONSIBLE PARTY INFORMATION (If patient is a minor, provide parent or legal guardian information.)

Name			
Last _____	First _____	MI _____	Preferred Name _____
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	Driver's License # _____		
Mailing Address _____			
How long at this address? _____ years	Previous Address (if less than 3 years) _____		
Home Phone _____	Cell Phone _____	Work Phone _____	Preferred number _____
Email addresses for appointment reminders, etc. _____			
Social Security # _____	Birth Date _____	Relationship to patient _____	
Employer _____	Occupation _____	Number of years employed _____	
Spouse's Name _____	Relationship to patient _____		
Social Security # _____	Birth Date _____	Phone _____	
Employer _____	Occupation _____	Number of years employed _____	

EMERGENCY CONTACT INFORMATION

Name _____
Phone Number(s) _____ Relationship to patient _____

PRIMARY DENTAL INSURANCE

Insured's Full Name _____	Birth Date _____
Social Security # _____	Relationship to patient _____
Insurance Company _____	Group # _____
Insurance Company Address _____	Contract # _____
Does this policy have orthodontic benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	Insurance Phone # _____
Insured's Employer _____	

SECONDARY DENTAL INSURANCE

Insured's Full Name _____	Birth Date _____
Social Security # _____	Relationship to patient _____
Insurance Company _____	Group # _____
Insurance Company Address _____	Contract # _____
Does this policy have orthodontic benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	Insurance Phone # _____
Insured's Employer _____	

GENERAL INFORMATION

What concerns the patient about his/her teeth and jaws? _____
Other family members with similar condition? _____
Who suggested that the patient might need orthodontic treatment? _____
Has the patient ever had any previous orthodontic treatment or consultation? _____
Why did you select our office? _____
What school does the patient attend? _____ Grade? _____
List interests and hobbies. _____

DENTAL HISTORY

Patient's dentist _____ Date of last exam? _____
Remaining recommended dental work? _____
How often does the patient have dental check-ups? _____
Have there been any injuries to the face, mouth or teeth? _____
Has the patient been informed of any missing or extra permanent teeth? * _____
Please check any of the following conditions that apply to patient:

<input type="checkbox"/> Bad Breath	<input type="checkbox"/> Crowns	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/> Sensitivity to Cold
<input type="checkbox"/> Bleeding	<input type="checkbox"/> Earaches	<input type="checkbox"/> Loose Teeth	<input type="checkbox"/> Sensitivity to Hot
<input type="checkbox"/> Bridgework	<input type="checkbox"/> False Teeth	<input type="checkbox"/> Mouth Breather	<input type="checkbox"/> Sensitivity to Sweets
<input type="checkbox"/> Broken Fillings	<input type="checkbox"/> Food Between Teeth	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Sensitivity when Biting
<input type="checkbox"/> Clicking/Popping Jaws	<input type="checkbox"/> Grinding Teeth	<input type="checkbox"/> Partial Dentures	<input type="checkbox"/> Sores/Growth in Mouth

MEDICAL HISTORY

Name of Physician _____ Date of last visit _____
Please list all medications patient is currently taking _____
Allergies _____
(Women) Is patient pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control? ☐ Yes ☐ No
Does patient have a history of any of the following?

<input type="checkbox"/> AIDS	<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cough, Persistent	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Skin Rash
<input type="checkbox"/> Arthritis, Rheumatism	<input type="checkbox"/> Cough Up Blood	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Artificial Heart Valves	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Major Surgery	<input type="checkbox"/> Swelling of Feet
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Mitral valve Prolapse	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fainting	<input type="checkbox"/> Nervous Problems	<input type="checkbox"/> Tobacco Habit
<input type="checkbox"/> Back problems	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Respiratory Disease	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatic Fever	
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Scarlet Fever	

Other _____
Describe heart problems _____ Does patient require premedication? ☐ Yes ☐ No

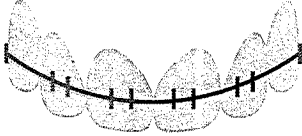
To the best of my knowledge, the two pages of information (front and back) are complete and correct. I give permission for any photographs, x-rays, or study models to be used for displays at scientific presentations and/or publications of a scientific nature or for group purposes to further the art and science of orthodontics. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature of Patient or Parent/Guardian if Patient is a Minor

Date

Printed Name of Patient or Parent/Guardian if Patient is a Minor

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ACKNOWLEDGMENT AND AGREEMENT WITH PRIVACY PRACTICES

Patient's Name: _____

DOB: ____ / ____ / ____

SSN: ____ — ____ — ____

Previous Name(s): _____

I understand the patient's protected health information ("PHI") is private and confidential. I understand **SAWRIE ORTHODONTICS** works very hard to protect a patient's privacy and preserve the confidentiality of a patient's personal health information.

I understand **SAWRIE ORTHODONTICS** may use and disclose the patient's PHI to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of PHI without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.

SAWRIE ORTHODONTICS possesses a detailed document called "Notice of Privacy Practices." It contains more information about the policies and practices protecting a patient's PHI, and is included as part of this Acknowledgment. I understand that I have the right to read the "Notice of Privacy Practices" before signing this Acknowledgment.

SAWRIE ORTHODONTICS may update this Acknowledgment and "Notice of Privacy Practices." If I ask, **SAWRIE ORTHODONTICS** will provide me with the most current "Notice of Privacy Practices." Within this "Notice of Privacy Practices" is a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to: access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law and requesting communication occur by specified methods of communication or alternative action.

SAWRIE ORTHODONTICS established procedures help it meet its obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non—routine information needs; etc. I will assist **SAWRIE ORTHODONTICS** by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices."

I read and fully understand the above acknowledgment, consent, and agreement with privacy practices.

Patient Signature

Date

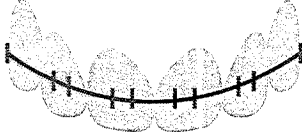
As patient's parent, legal guardian, or personal representative, I consent to treatment reasonably necessary for _____

Signature of Parent, Legal Guardian, or Personal Representative

Date

Print Full Name

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION ("PHI")

Name of Patient: _____

DOB: ____ / ____ / ____

SAWRIE ORTHODONTICS is authorized to release protected health information ("PHI") about the above named patient to the entities named below.

I hereby authorize **SAWRIE ORTHODONTICS** to release my PHI and other medical information to my health insurance provider, and understand the federal standards of PHI release (i.e., HIPAA) are being followed by this practice. Further information can be obtained by requesting it from the receptionist or Privacy Officer.

Entity to Receive Information. Initial each that is subject to this authorization.

____ Leave information on the voice mail.

____ Give information to spouse.

____ Give information to following persons: _____

Description of Information to be released.

____ Financial information.

____ Family billing information.

____ Information results from tests or x-rays.

____ Medical information as follows: _____

____ Other information as described: _____

Time Limit: _____

RIGHTS OF THE PATIENT

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the Protected Health Information to be disclosed as described in this document by sending a written notification to **SAWRIE ORTHODONTICS**.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This Authorization shall be in force and effect until revoked by the patient or representative signing the Authorization.

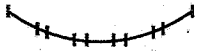
Patient Signature

Date

Signature of Parent, Legal Guardian, or Personal Representative

Date

Print Full Name



TENNESSEE ASSOCIATION OF ORTHODONTICS

Potential Risks and Limitations Orthodontic Treatment

Generally, excellent orthodontic results can be achieved with informed and cooperative patients. You should be aware that orthodontic treatment, like treatment of any part of the body, has some risks and limitations. These are seldom severe enough to offset advantages of treatment, but they should be considered in making the decision to undergo orthodontic treatment.

Tooth decay, gum disease, and permanent markings (decalcification) on the teeth can occur in patients who do not brush their teeth frequently and properly, or if they eat foods or soft drinks containing excessive sugar. These same problems can also occur in patients not wearing braces, but of course, the risk is greater while wearing orthodontic appliances. There have been a few reports injury to the eyes of patients wearing headgear. In every case, the patient was engaged in horseplay or other strenuous activity when wearing the appliances. Patients are advised not to wear the headgear during such activities.

A tooth that has been traumatized by an injury, or a tooth that has a large filling, may require endodontic (root canal) treatment when it is moved with orthodontic appliances. Sometimes a tooth may have a non-vital or damaged nerve and orthodontic movement may reveal the need of endodontic treatment.

In some patients the length of the roots of the teeth may be shortened during orthodontic treatment. Usually this is of no significant consequence, but on rare occasions it may become a serious threat to the longevity of the teeth involved.

Nothing is forever in the human body. This is, of course, true of teeth. Teeth which have been moved by braces do not stay exactly where they were at the time the braces were removed. Faithfully wearing a retainer can reduce the tendency for movement after treatment. The lower front teeth are the ones that most frequently experience changes. Also, the relationship of the upper and lower teeth can change adversely due to such problems as chronic mouth breathing, abnormal tongue posture and abnormal posture. Occasionally, unexpected or abnormal changes in the growth of the jaws may limit the orthodontist's ability to achieve the desired result. If growth becomes disproportionate, the relationship of the upper jaw to the lower jaw may change, requiring additional treatment, or in some cases, surgery. Uneven growth is a biological process that is beyond the scope of orthodontic control.

There is a risk that problems might occur in the temporomandibular joint (TMJ) located under the skin just in front of the ear. Many things cause TMJ problems. For example, one may have suffered a blow to the head or jaw in this area as a child or have arthritis in the area. At this time, there is no scientific evidence that links orthodontic treatment to any kind of TMJ problem. A problem which is in the area before the braces are placed might show up while the patient is wearing braces. Like any other joint in the body, the TM joint is affected by aging. A problem may develop years after the braces are removed. This does not mean that the braces were related to the TM joint problem.

As an aid to orthodontic treatment, it is sometimes necessary to remove permanent teeth. When teeth are extracted it is possible that space will open in the extraction site after the braces are removed. This space is seldom a health or cosmetic problem. If space does occur and it is a problem, it may be necessary to institute restorative dental procedures to close the space.

When teeth are impacted and the treatment of choice is to try to orthodontically move the teeth into a proper alignment, it may be necessary to have these teeth surgically exposed. When surgery is performed, there may be some compromise of tissue or bone and it may be necessary to repair this soft tissue or bone. It is also possible that the impacted tooth will not respond to orthodontic treatment. It would, therefore, have to be removed. It is very difficult to project a specific amount of treatment time necessary to properly align an impacted tooth, therefore, alignment of an impacted tooth may prolong the total time in orthodontic treatment.

The total time for treatment may be longer than estimated. Remember that poor cooperation, broken and/or missed appointment and habitual appliance breakage will lengthen the treatment and lessen the quality of the result.

Potential benefits of orthodontic treatment outweigh any risks which can be reasonably anticipated. If you have any questions about treatment and the potential risks involved, please do not hesitate to ask for further explanation.

Your signature below certifies that you have read and understood the above and consent to orthodontic treatment for the patient named below. Also, your signature certifies that you grant permission to the orthodontists to use clinical photographs, x-rays and casts of the patient named below in scientific journals or publications.

PATIENT _____

Signature of Parent (if patient is a minor) or Patient

DATE