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

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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? ☐No ☐Yes: _____

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

Name
Last _____ First _____ MI _____ Preferred Name _____
Marital Status ☐Single ☐Married ☐Divorced ☐Separated ☐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 # _____ Contract # _____
Insurance Company Address _____
Does this policy have orthodontic benefits? ☐Yes ☐No ☐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 # _____ Contract # _____
Insurance Company Address _____
Does this policy have orthodontic benefits? ☐Yes ☐No ☐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:

☐ Bad Breath	☐ Crowns	☐ Jaw Pain	☐ Sensitivity to Cold
☐ Bleeding	☐ Earaches	☐ Loose Teeth	☐ Sensitivity to Hot
☐ Bridgework	☐ False Teeth	☐ Mouth Breather	☐ Sensitivity to Sweets
☐ Broken Fillings	☐ Food Between Teeth	☐ Neck Pain	☐ Sensitivity when Biting
☐ Clicking/Popping Jaws	☐ Grinding Teeth	☐ Partial Dentures	☐ 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?

☐ AIDS	☐ Circulatory Problems	☐ HIV Positive	☐ Shortness of Breath
☐ Anemia	☐ Cough, Persistent	☐ Kidney Disease	☐ Skin Rash
☐ Arthritis, Rheumatism	☐ Cough Up Blood	☐ Liver Disease	☐ Stroke
☐ Artificial Heart Valves	☐ Diabetes	☐ Major Surgery	☐ Swelling of Feet
☐ Artificial Joints	☐ Epilepsy	☐ Mitral valve Prolapse	☐ Thyroid Problems
☐ Asthma	☐ Fainting	☐ Nervous Problems	☐ Tobacco Habit
☐ Back problems	☐ Glaucoma	☐ Pacemaker	☐ Tonsillitis
☐ Blood Disease	☐ Heart Murmur	☐ Psychiatric Care	☐ Tuberculosis
☐ Blood Transfusion	☐ Heart Problems	☐ Radiation Treatment	☐ Ulcer
☐ Cancer	☐ Hemophilia	☐ Respiratory Disease	☐ Venereal Disease
☐ Chemical Dependency	☐ Hepatitis	☐ Rheumatic Fever	
☐ Chemotherapy	☐ High Blood Pressure	☐ 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 alterative 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. **Time Limit:** _____

____ Family billing information.

____ Information results from tests or x-rays.

____ Medical information as follows: _____

____ Other information as described: _____

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

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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 awar 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 makings (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 desire result. If growth becomes disproportionate, the relationship of the upper jaw to the lower law may change, requiring additions 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 issue or bone arid 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 out weigh 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 certified 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