

PATIENT INFORMATION

Business phone#() Business Address Street City State Chief reason you are seeking treatment First Middle Last Employer Position/Occupation Cell#() Business address Street City State Zip Insurance Information Responsible Party First Middle Last Home address Street City State Zip First Middle Last First Middle Last	First	Middl	le	Las	st	L _D V
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Street City State Zip Home phone#(_)	Marital status: Single M					
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State Zip	mployer	Position/Occupat	tion	Cell		
A dental insurance policy is a contract but were	Employer			Busine		
A dental insurance policy is a contract between the insured and the insurance company. Our professional ser endered and charged directly to the patient's account and the person responsible for payment of all fees incu onvenience, we will gladly assist you in submitting your insurance along the person in the payment of all fees incu	Business addressStreet	City	State	Busine Zip	ess Phone#()	
onvenience, we will gladly assist you in submitting your insurance claim by providing you with the necessary orm, filling in our part, and mailing it for you.	Business addressStreet I dental insurance policy is a coendered and charged directly to	City ontract between the insure	State	Busine Zip	ess Phone#()	
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Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your dental care. All information will be kept completely confidential.

MEDICAL HISTORY

Physician's Name	Address	Phone
Have you experienced any health problem. Any major change in your health recently Are you currently under a physician's can Are you currently taking any medications? Are you allergic to any medications? Have you received a blood transfusion? Have your tonsils or adenoids been remortance.	/? No Yes Explain re? No Yes Explain re? No Yes List No Yes List No Yes Reason ved? No Yes When No Yes Explain	
Please check if you have had any of the for Heart Murmur. No Yes Heart Surgery. No Yes Rheumatic Fever No Yes Endocrine Disorders. No Yes Prolonged Bleeding. No Yes Anemia No Yes Blood Disease. No Yes Developmental Disorder. No Yes Hives/Rash. No Yes	Hepatitis No Yes Diabetes No Yes Kidney Disease No Yes Liver Disease No Yes Tuberculosis No Yes Bronchitis No Yes Asthma No Yes Epilepsy No Yes Fainting No Yes	Frequent HeadachesNo Yes Nervous/AnxiousNo Yes CancerNo Yes Bone DisordersNo Yes Growth DisordersNo Yes Mouth BreatherNo Yes Herpes (fever blisters)No Yes TonsilitisNo
	you should know about	11?
DOMESTICS AND THE PROPERTY OF	DENTAL HISTORY	
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CHILD PATIENT INFORMATION

DATE				
PATIENT NAME				
	First	Middle		Last
MaleFemale	_ DOB	Age_	S.S.	#:
Home address				
			State	5753.500
School Name			School Grade	
				11
		Separated Divor		
		Family Inf	ormation	
Father				
F	irst	Middle	Last	
DOB	S.:	S. #:	_ Emai	
				cell#()
				iness Phone#()
Mother				
	irst	Middle	Last	
DOB	S.S	S. #:	Emai	
Home address				
Employer		Position/Occupation	c	ell#()
Business address			Busi	ness Phone#()
		Insurance In		
Person Responsible	for Account:_	modiance m		
A dental insurance policy charged directly to the pa	is a contract be	tween the insured and the insu	rance company. Our pr	ofessional services are rendered and rred. for your convenience, we will gladly rm, filling in our part, and mailing it for you
Responsible Party Sign	nature			Date

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your dental care. All information will be kept completely confidential.

MEDICAL HISTORY

rnysician s Name	Address	Phone
lave you experienced any health problems?) No V 7 11	
Any major change in your health recently?		
Are you currently under a physician's care?	No Yes Explain	
Are you currently taking any medications?		
Are you allergic to any medications?	INO LES LIST	
lave you received a blood transfusion?	No_Yes_List	
lave your tonsils or adenoids been removed		
lave you been in a risk group for HIV?		
lave you been in a risk group for HIV?	No_Yes_Explain	
lease check if you have had any of the folk		
leart MurmurNo_Yes	owing conditions:	
eart SurgeryNo_Yes_	HepatitisNo_Yes_	
heumatic FeverNo_Yes_	DiabetesNo_Yes_	Frequent HeadachesNo Ves
ndocrine DisordersNo_Yes_	Kidney DiseaseNo Yes	Nervous/AnxiousNo Yes
rolonged Planding No Yes	Liver DiseaseNo_Yes_	CancerNo_Yes_
rolonged BleedingNo_Yes_	Tuberculosis No_Yes	Bone Disorders No. Van
nemiaNo_Yes_	BronchitisNo_Yes	Cirowth Disorders No. V.
lood DiseaseNo_Yes_	AsthmaNo Yes	Mouth Breather No Vos
Developmental DisorderNo_Yes_	EpilepsyNo_Yes_	
lives/RashNo_Yes_	FaintingNo_Yes_	Herpes (fever blisters)No Yes
there any other condition or problem that y	you think we should know about	?
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HIPPA PATIENT COMMUNICATION FORM

FAMILY & FRIENDS: It is the policy of this office not to release confidential medical information regarding your treatment to family members or friends except for into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment, in emergency situations, or as otherwise permitted by the health insurance portability and accountability act of 1996 (HIPPA).

PARENT: YES NO OTHER: YES NO OTHER: YES NO Alternative communications: You are also entitled to specify alternative reasonable means of communication, if you do not wish to be cont us in a certain way. HOME (ANSWERING MACHINE) YES NO WORK (ANSWERING MACHINE) YES NO WORK (ANSWERING MACHINE) YES NO WORK (ANSWERING MACHINE) YES ACKNOWLEDGEMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES NAME OF PATIENT: I hereby acknowledgement that a copy of this medical practice's Notice of Privacy Practices is available in the reception area and that I may namended Notice of Privacy Practices at each appointment. Informed Consent Informed Consent Informed Consent Informed Consent Informed Consent Deming Orthodontics To forward any medical information to the referring physician(s) regarding (my/my child's) illness and treatment information to my employer and/or their insurance carrier (for workers' compensation only). I understand the information released may also of the Connecticut General Statutes. This information had not be forwarded to anyone else without my written consent or other payments to Deming Orthodontics to release to the insurance carrier any information needed for the payment of any claim. I permit a copy of this a payments to Deming Orthodontics from my insurance carrier and agree to pay any applicable co-payments at the time of service. I unclaim insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance. CERTIFY THAT I HAVE READ THIS AGREEMENT, THAT I AM THE PATIENT (OR THE LEGAL GUARDIAN FOR A MINOR), AND I ACCERTANDOVE.	By signing below, you this in writing).
Alternative communications: You are also entitled to specify alternative reasonable means of communication. If you do not wish to be contuined us in a certain way. HOME (ANSWERING MACHINE) YES NO WORK (ANSWERING MACHINE) YES NO WORK (ANSWERING MACHINE) YES ACKNOWLEDGEMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES NAME OF PATIENT: I hereby acknowledgement that a copy of this medical practice's Notice of Privacy Practices is available in the reception area and that I may not amended Notice of Privacy Practices at each appointment. Informed Consent Informed Consent Informed Consent Jauthorize: Deming Orthodontics To forward any medical information to the referring physician(s) regarding (my/my child's) lilness and treatment information to my employer and/or their insurance carrier for workers' compensation only). I understand the information released may also the Connecticut General Statutes. This information shall not be forwarded to anyone else without my written consent or other. Deming Orthodontics to release to the insurance carrier any information needed for the payment of any claim. I permit a copy of this a payments to Deming Orthodontics to release to the insurance carrier any information needed for the payment of any claim. I permit a copy of this a Payments to Deming Orthodontics from my insurance carrier and agree to pay any applicable co-payments at the time of service. I unclinearing benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance. CERTIFY THAT I HAVE READ THIS AGREEMENT, THAT I AM THE PATIENT (OR THE LEGAL GUARDIAN FOR A MINOR), AND I ACCERBOVE.	
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	PT THE TERMS AS
	Date
Signature of Responsible Party Relationship to Patient	

If you have been assigned guardianship of the minor patient, you must present proof of guardianship, such as a court document or DCF paperwork.



Chart #

Robert E. Brewka, DDS, MS
Diplomate of the American Board of Orthodontics
710 S. Gold St. Deming, NM 88030
P: 575-546-1400 E: demingortho@gmail.com

Photo Release Form

Date:	
Name of Model:	
Address:	
Phone Number:	
Patient's Age:	
ا hereby و their website and	grant Deming Orthodontics the absolute right to use my photograph to publish on on d/or Facebook.
l am of leg consent or know	gal age and have the full legal capacity to execute this authorization without the ledge of any other person.
l understa	and I have no interest in the copyright, or any moral rights, in the photograph.
Parent Name	
Parent/Patient	
Signature	Date:



For the orthodontic treatment of

Date

(Witness)

Orthodontic treatment remains an elective procedure. It, like any other treatment of the body, has some inherent risks and limitations. These seldom prevent treatment, but should be considered in making the decisionto undergo treatment.

COOPERATION IS A PREDICTABLE FACTOR THAT CAN AFFECT THE OUTCOME OF ORTHODONTIC

TREATMENT: In the vast majority of orthodontic cases, significant improvements can be achieved with patient cooperation. Excessive treatment time and/or compromised results can occur from non-cooperation. For example:

- Caring for appliances- Poor oral hygiene increases the risk of decay and periodontal disease when wearing braces.
 Routine visits every 3 to 6 months to your dentist for cleanings and cavity checks are still necessary.
- Wearing headgear and elastics- Theseare forces placed on teeth so that they will move into their proper relationships. The amount of time these are worn, affects the results. Please wear them as instructed.
- 3. Keeping appointments- Missed appointments create many scheduling problems and lengthen treatment time.

UNPREDICTABLE FACTORS THAT CAN AFFECT THE OUTCOME OF ORTHODONTIC TREATMENT:

- Muscle Habits- Mouth breathing, thumb finger, or lip sucking, tongue thrusting(abnormal swallowing) and other unusual habits can prevent the teeth from moving to their corrected positions or cause relapse after braces are removed.
- Facial Growth Patterns- Unusual skeletal patterns or unpredicable facial growth may compromise the occlusion, or fit of upper and lower teeth. Surgical assistance may be recommended in these situations.
- Post Treatment Tooth Movement- Teeth mayt have a tendency to shift or settle after treatment as well as after retention. some changes are desirable, while others are not.
- 4. Temporomandibular Joint (TMJ) Problems- Possible TMJ problems may develop at any time before, during, or after orthodontic treatment. Tooth position, bite, or non-symptomatic, preexisting TMJ problems can be a factor in this condition. Often, an occlusal guard, or night guard, may be helpful.
- Imported Teeth- In attempting to move impacted teeth (teeth unable to erupt normally), especially cuspids (canine teeth) and third molars (wisdome teeth), various problems are sometimes encountered which may lead to periodontal problems, relapse, or loss of teeth.
- Root Resorption- Shortenint of root ends can occur when teeth are moved during orthodontic treatment. Under healthy conditions the shortened roots usually pose no problem. Trauma, impaction, endocrine disorders, or idiopathic (unknown) reasons also cause this problem. Severe resorption may increase the possibility of premature tooth loss in the presence of periodontal disease.
- Non-vital or Dead Tooth- A tooth traumatized by a blow or other causes can die over a long preiod of time with or
 without orthodontic treatment. This tooth may discolor or flare up during orthodontic movement and require
- Periodontal Problems (gum disease)- This condition can be present before or develop during treatment. It could deteriorate during treatment causing loss of bone around the teeth. Excellent oral hygiene and frequent prophylaxisby your dentist can help control this situation.
- 9. Unusual Occurrences- Swallowing appliances, chipping teeth, and dislodging restorations could be factors also.
 - I CONSENT TO THE TAKING OF PHOTOGRAPHS AND X-RAYS BEFORE, DURING, AND AFTER TREATMENT, AND TO THE USE OF SAME BY THE DOCTOR IN SCIENTIFIC PAPERS OR DEMONSTRATIONS
 I CERTIFY THAT I HAVE READ, OR HAD READ TO ME, THE CONTENTS OF THIS FORM AND REALIZE THE RISKS AND LIMITATIONS INVOLVED, AND DO HEREBY CONSENT TO ORTHODONTIC TREATMENT

 (Patient, Parent, or Guardian)

 (Patient, Parent, or Guardian)