Deming Orthodontics
Great Smiles without the Miles

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

PATIENT INFORMATION

DATE_____

PATIENT NAME_____
First Middle Last

Male____Female____ Date of birth_____ Age_____

Marital status: Single____ Married____ Partnered____ Divorced____ Widowed____

Home address_____
Street City State Zip

Home phone#(___)_____ Cell#(___)_____ Email_____

Employer_____ Position/Occupation_____

Business phone#(___)_____ Business Address_____
Street City State Zip

Chief reason you are seeking treatment_____

Family Information

Spouse/Partner_____
First Middle Last

Employer_____ Position/Occupation_____ Cell#(___)_____

Business address_____ Business Phone#(___)_____
Street City State Zip

Insurance Information

Responsible Party_____
First Middle Last

Home address_____
Street City State Zip

Employer_____ Position/Occupation_____ Cell#(___)_____

Business address_____ Business Phone#(___)_____
Street City State Zip

A dental insurance policy is a contract between the insured and the insurance company. Our professional services are rendered and charged directly to the patient's account and the person responsible for payment of all fees incurred. for your convenience, we will gladly assist you in submitting your insurance claim by providing you with the necessary orthodontic form, filling in our part, and mailing it for you.

Responsible Party Signature_____ 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

Physician's Name_____ Address_____ Phone_____

Have you experienced any health problems? No__Yes__Explain_____
Any major change in your health recently? No__Yes__Explain_____
Are you currently under a physician's care? No__Yes__Explain_____
Are you currently taking any medications? No__Yes__List_____
Are you allergic to any medications? No__Yes__List_____
Have you received a blood transfusion? No__Yes__Reason_____
Have your tonsils or adenoids been removed? No__Yes__When_____
Have you been in a risk group for HIV? No__Yes__Explain_____

Please check if you have had any of the following conditions:

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__

Emotional Problems.....No__Yes__
Frequent Headaches.....No__Yes__
Nervous/Anxious.....No__Yes__
Cancer.....No__Yes__
Bone Disorders.....No__Yes__
Growth Disorders.....No__Yes__
Mouth Breather.....No__Yes__
Herpes (fever blisters).....No__Yes__
Tonsilitis.....No__Yes__

Is there any other condition or problem that you think we should know about?_____
Comments_____

DENTAL HISTORY

Dentist's Name_____ Address_____ Phone_____
Frequency of dental checks:
Twice a year__ Once a year__ Only if a problem exists__ Never__ Date of last visit_____
Is there any unfinished care to be completed with your dentist? No__Yes__Explain_____
Are you frightened about dental treatment? No__Yes__Explain_____
Have you had an unpleasant experience in a dental office? No__Yes__Explain_____
Have you had any facial or dental injuries? No__Yes__Explain_____
Do you play a musical instrument? No__Yes__Which?_____
Have you consulted an orthodontist previously? No__Yes__With whom?_____
Have teeth (either primary or permanent) been removed? No__Yes__
Have you had any previous orthodontic treatment? No__Yes__With whom?_____
Are you satisfied with prior treatment? No__Yes__Explain_____
Have you noticed any changes in your bite or dental alignment recently? No__Yes__Explain_____
What are the chief concerns you have related to the position of your teeth or bite:
Aesthetic___ Cleaning___ Comfort___ Ability to Chew___ Stability___
Please elaborate: _____

Please check if there is a history of:
Clenching teeth__ Muscular soreness around head and neck__ Jaw joint soreness__ Jaw joint popping__
Grinding teeth__ Headaches (more than normal)__ Jaw joint clicking__ Ringing in the ears__
Mouth Breathing: __ Awake __ Asleep __
Speech problems No__ Yes__ If so, which sounds?_____
Is there any other information that may be helpful?_____

Patient's Signature_____ Date_____ Reviewed by_____

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CHILD PATIENT INFORMATION

DATE_____

PATIENT NAME_____
First Middle Last

Male____Female____ DOB_____ Age_____ S.S. #:_____

Home address_____
Street City State Zip

School Name_____ School Grade_____

Patient's Interests:_____

Please describe your child's orthodontic problem in your own words_____

Whom may we thank for referring you to our office?_____

Parent's Marital Status: Married_____ Separated_____ Divorced_____ Widowed_____ Single_____

Family Information

Father_____
First Middle Last

DOB_____ S.S. #:_____ Emai_____

Home address_____

Employer_____ Position/Occupation_____ Cell#(___)_____

Business address_____ Business Phone#(___)_____

Mother_____
First Middle Last

DOB_____ S.S. #:_____ Emai_____

Home address_____

Employer_____ Position/Occupation_____ Cell#(___)_____

Business address_____ Business Phone#(___)_____

Insurance Information

Person Responsible for Account:_____

A dental insurance policy is a contract between the insured and the insurance company. Our professional services are rendered and charged directly to the patient's account and the person responsible for payment of all fees incurred. for your convenience, we will gladly assist you in submitting your insurance claim by providing you with the necessary orthodontic form, filling in our part, and mailing it for you.

Responsible Party Signature_____ 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

Physician's Name_____ Address_____ Phone_____

Have you experienced any health problems? No__Yes__Explain_____
Any major change in your health recently? No__Yes__Explain_____
Are you currently under a physician's care? No__Yes__Explain_____
Are you currently taking any medications? No__Yes__List_____
Are you allergic to any medications? No__Yes__List_____
Have you received a blood transfusion? No__Yes__Reason_____
Have your tonsils or adenoids been removed? No__Yes__When_____
Have you been in a risk group for HIV? No__Yes__Explain_____

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Anemia.....No__Yes__
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Comments_____

DENTAL HISTORY

Dentist's Name_____ Address_____ Phone_____
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Twice a year__ Once a year__ Only if a problem exists__ Never__ Date of last visit_____
Is there any unfinished care to be completed with your dentist? No__Yes__Explain_____
Are you frightened about dental treatment? No__Yes__Explain_____
Have you had an unpleasant experience in a dental office? No__Yes__Explain_____
Have you had any facial or dental injuries? No__Yes__Explain_____
Do you play a musical instrument? No__Yes__Which?_____
Have you consulted an orthodontist previously? No__Yes__With whom?_____
Have teeth (either primary or permanent) been removed? No__Yes__
Have you had any previous orthodontic treatment? No__Yes__With whom?_____
Are you satisfied with prior treatment? No__Yes__Explain_____
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Aesthetic__ Cleaning__ Comfort__ Ability to Chew__ Stability__
Please elaborate: _____

Please check if there is a history of:
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Mouth Breathing: __ Awake __ Asleep __
Speech problems No__ Yes__ If so, which sounds?_____
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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 **parent/legal guardian**, other persons authorized by the patient, as we may reasonably infer from the circumstances (for example, if you bring a family member or frie 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**).

If you need or want your medical information to be provided to family members, friends, or caretakers/ babysitters, please indicate that below. By signing below, you **authorize** the following people to receive information regarding your treatment or care: (**If you wish to add names later on, please confirm this in writing**).

SPOUSE:_____ _____ **YES** _____ **NO**

PARENT: _____ _____ **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 contacted by us in a certain way.

HOME (ANSWERING MACHINE) _____ **YES** _____ **NO** WORK (ANSWERING MACHINE) _____ **YES** _____ **NO**

I HEREBY REQUEST THE FOLLOWING MEANS OF CONTACT ONLY: _____

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 request of copy of any amended **Notice of Privacy Practices** at each appointment.

Informed Consent - I authorize:

- Deming Orthodontics To forward any medical information to the referring physician(s) regarding (my/my child's) illness and treatment and to submit information to my employer and/or their insurance carrier (for workers' compensation only). I understand the information released may include psychiatric, drug, alcohol, and/or HIV/AIDS information/ the confidentiality of this record is protected by the Federal Confidentiality Regulations 42 CFR 9 part 2 chapter 899c of the Connecticut General Statutes. This information shall not be forwarded to anyone else without my written consent or other authorization as provided in the statutes.
- Deming Orthodontics to release to the insurance carrier any information needed for the payment of any claim. I permit a copy of this authorization to be use in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.
- Payments toDeming Orthodontics from my insurance carrier and agree to pay any applicable co-payments at the time of service. I understand that my heal insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance.
- Testing and treatment procedures as deemed necessary by the Deming Orthodontics Orthodontist.

I CERTIFY THAT I HAVE READ THIS AGREEMENT, THAT I AM THE PATIENT (OR THE LEGAL GUARDIAN FOR A MINOR), AND I ACCEPT THE TERMS AS ABOVE.

_____ _____
Patient Signature Date

If patient is a minor:

_____ _____ _____
Signature of Responsible Party Relationship to Patient Date

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

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Photo Release Form

Chart #: _____
Date: _____
Name of Model: _____
Address: _____
_____
Phone Number: _____
Patient's Age: _____

I hereby grant Deming Orthodontics the absolute right to use my photograph to publish on on their website and/or Facebook.

I am of legal age and have the full legal capacity to execute this authorization without the consent or knowledge of any other person.

I understand I have no interest in the copyright, or any moral rights, in the photograph.

Parent Name _____

Parent/Patient Signature _____ Date: _____

Informed Consent

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For the orthodontic treatment of

Date

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:

1. 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.
2. 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:

1. 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.
2. 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.
3. 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.
5. Impcted 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.
6. 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.
7. 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 endodontic treatment (a root canal).
8. 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)

_____
(Witness)