WELCOME TO OUR PRACTICE!

Please fill out completely and bring with you to the Consultation Appointment!

Today's Date:_____ Name:_____

Home Address:_____

City State Zip

DOB :_____ Age :_____ Home # :_____ Cell # :_____

Whom may we thank for referring you?_____ Work # :_____ Ext:_____

Other family seen by us:_____ E-Mail_____ SS # :_____

Spouse Information

Name:_____

Employer:_____

Cell # :_____ Work # :_____

SS # :_____

DL # :_____

DOB :_____ E-Mail_____

Employer Information

Name:_____

Address :_____

How long have you worked there? _____

When & Where are the best times to reach you? _____

_____

Occupation :_____

Dental Information

Present/Previous Dentist :_____

Address :_____

_____

Phone # :_____

Last Visit :_____

Emergency Contact

Name :_____

Relation:_____

Home # :_____ Cell # :_____

Work # :_____ Ext. :_____

Primary Dental Insurance

Ins. Name :_____

Ins. Address :_____

Ins. Phone # :_____

Insured's Name:_____

Relationship to Pt:_____

Insured's Employer:_____

Insured's DOB:_____

Insured's SS # :_____

Orthodontic Coverage: YES NO

Secondary Dental Insurance

Ins. Name :_____

Ins. Address :_____

Ins. Phone # :_____

Insured's Name:_____

Relationship to Pt:_____

Insured's Employer:_____

Insured's DOB:_____

Insured's SS # :_____

Orthodontic Coverage: YES NO

Dental History

Why are you here today? _____

_____

Your current dental health is: GOOD FAIR POOR

Have you ever had a serious/difficult problem associated with previous dental work?

YES NO

Have you ever had any pain or tenderness in the jaw joint (TMJ/TMD)?

YES NO

Do you like your smile? YES NO

Do your gums ever bleed? YES NO

How many times a week do you floss?_____

How many times a day do you brush? _____

Have you ever had any of the following diseases or medical problems?

Y	N	Prosthesis	Y	N	Hist. Of Scarlet Fev.
Y	N	Heart Attack	Y	N	Congenital Heart Def.
Y	N	Cancer	Y	N	Convulsions/Epilepsy
Y	N	Diabetes	Y	N	Abnormal Bleeding
Y	N	Rheum. Fev.	Y	N	Artificial Valves
Y	N	HIV+/AIDS	Y	N	Heart Surg./Pacmkr.
Y	N	Hemophilia	Y	N	Kidney/Liver Probs.
Y	N	Asthma	Y	N	Mitral Valve Prolapse
Y	N	Hepatitis	Y	N	Artificial bones/joints
Y	N	Tuberculosis	Y	N	Sev./Freq. Headaches
Y	N	Shingles	Y	N	Hi/Lo Blood Pressure
Y	N	Fever Blister	Y	N	Drug/Alcohol Abuse
Y	N	Venereal Dis.	Y	N	Blood Transfusion
Y	N	Ulcers/Colitis	Y	N	Anemia/Radiation Tmt.
Y	N	Heart Murm.	Y	N	Glaucoma
Y	N	Emphysema	Y	N	Difficulty Breathing
Y	N	Sinus Probs.	Y	N	Any Hospital Stays:
Y	N	Other:_____			

_____ _____

_____

Medical History

Do you have a personal physician? YES NO

Name:_____

Phone # :_____ Last Visit:_____

Your current physical health is: GOOD FAIR POOR

Are you currently under the care of a doctor? YES NO

If YES above, please explain:_____

_____

Are you currently taking any prescription or non-prescription drugs?

YES NO

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Tetracycline
Y	N	Codeine	Y	N	Other:_____
Y	N	Latex			
Y	N	Penicillin			
Y	N	Erythromycin			
Y	N	Dental Anesthetics			

_____

_____

For Women Only

Are you taking birth control pills? YES NO

Are you pregnant? YES NO Week # :_____

Are you nursing? YES NO

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental staff to perform the necessary dental services I may need during treatment.

Signature:_____ Date:_____

PAYMENT IS DUE IN FULL AT TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

*****OFFICE USE ONLY***OFFICE USE ONLY***OFFICE USE ONLY*****

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Initials:_____ Date:_____ Doctor's comments:_____

RICKABAUGH ORTHODONTICS

INFORMED CONSENT

for the Orthodontic Patient

Risks and Limitations of Orthodontic Treatment

Successful orthodontic treatment is a partnership between the orthodontist and the patient. The doctor and staff are dedicated to achieving the best possible result for each patient. As a general rule, informed and cooperative patients can achieve positive orthodontics results. While recognizing the benefits of a beautiful healthy smile, you should also be aware that, as with all healing arts, orthodontic treatment has some limitations and potential risks. These are seldom serious enough to indicate that you should not have treatment; however, all patients should seriously consider the option of no orthodontic treatment at all by accepting their present oral condition. Alternative to orthodontic treatment vary with the individual's specific problem, and prosthetic solutions or limited orthodontic treatment may be considerations. You are encouraged to discuss alternatives with doctor prior to beginning treatment.

Orthodontics and Dentofacial Orthopedics is the dental specialty that includes the diagnosis, prevention, interception and correction of malocclusion, as well as neuromuscular and skeletal abnormalities of the developing or mature orofacial structures.

An orthodontist is a dental specialist who has completed at least two additional years of graduate training in orthodontics at an accredited program after graduation from dental school.

AAO American Association of Orthodontists®

INFORMED CONSENT for the Orthodontic Patient

Results of Treatment

Orthodontic treatment usually proceeds as planned, and we intend to do everything possible to achieve the best results for every patient. However, we cannot guarantee that you will be completely satisfied with your results, nor can all complications or consequences be anticipated. The success of treatment depends on your cooperation in keeping appointments, maintaining good oral hygiene, avoiding loose or broken appliances, and following the orthodontist's instructions carefully.

Length of Treatment

The length of treatment depends on a number of issues, including the severity of the problem, the patient's growth and the level of patient cooperation. The actual treatment time is usually close to the estimated treatment time, but treatment may be lengthened if, for example, unanticipated growth occurs, if there are habits affecting the dentofacial structures, if periodontal or other dental problems occur, or if patient cooperation is not adequate. Therefore, changes in the original treatment plan may become necessary. If treatment time is extended beyond the original estimate, additional fees may be assessed.

Discomfort

The mouth is very sensitive so you can expect an adjustment period and some discomfort due to the introduction of orthodontic appliances. Non-prescription pain medication can be used during this adjustment period.

Relapse

Completed orthodontic treatment does not guarantee perfectly straight teeth for the rest of your life. Retainers will be required to keep your teeth in their new positions as a result of your orthodontic treatment. You must wear your retainers as instructed or teeth may shift, in addition to other adverse effects. Regular retainer wear is often necessary for several years following orthodontic treatment. However, changes after that time can occur due to natural causes, including habits such as tongue thrusting, mouth breathing, and growth and maturation that continue throughout life. Later in life, most people will see their teeth shift. Minor irregularities, particularly in the lower front teeth, may have to be accepted. Some changes may require additional orthodontic treatment or, in some cases, surgery. Some situations may require non-removable retainers or other dental appliances made by your family dentist.

Extractions

Some cases will require the removal of deciduous (baby) teeth or permanent teeth. There are additional risks associated with the removal of teeth which you should discuss with your family dentist or oral surgeon prior to the procedure.

Orthognathic Surgery

Some patients have significant skeletal disharmonies which require orthodontic treatment in conjunction with orthognathic (dentofacial) surgery. There are additional risks associated with this surgery which you should discuss with your oral and/or maxillofacial surgeon prior to beginning orthodontic treatment. Please be aware that orthodontic treatment prior to orthognathic surgery often only aligns the teeth within the individual dental arches. Therefore, patients discontinuing orthodontic treatment without completing the planned surgical procedures may have a malocclusion that is worse than when they began treatment!

Decalcification and Dental Caries

Excellent oral hygiene is essential during orthodontic treatment as are regular visits to your family dentist. Inadequate or improper hygiene could result in cavities, discolored teeth, periodontal disease and/or decalcification. These same problems can occur without orthodontic treatment, but the risk is greater to an individual wearing braces or other appliances. These problems may be aggravated if the patient has not had the benefit of fluoridated water or its substitute, or if the patient consumes sweetened beverages or foods.

Root Resorption

The roots of some patients' teeth become shorter (resorption) during orthodontic treatment. It is not known exactly what causes root resorption, nor is it possible to predict which patients will experience it. However, many patients have retained teeth throughout life with severely shortened roots. If resorption is detected during orthodontic treatment, your orthodontist may recommend a pause in treatment or the removal of the appliances prior to the completion of orthodontic treatment.

Nerve Damage

A tooth that has been traumatized by an accident or deep decay may have experienced damage to the nerve of the tooth. Also, the nerve of a tooth may die for no apparent reason, and this is known as "spontaneous pulpal necrosis." Orthodontic tooth movement may, in some cases, aggravate these conditions and cause root canal treatment to be necessary. In severe cases, the tooth or teeth, may be lost.

Periodontal Disease

Periodontal (gum and bone) disease can develop or worsen during orthodontic treatment due to many factors, but most often due to the lack of adequate oral hygiene. You must have your general dentist, or if indicated, a periodontist monitor your periodontal health during orthodontic treatment every three to six months. If periodontal problems cannot be controlled, orthodontic treatment may have to be discontinued prior to completion.

Injury From Orthodontic Appliances

Activities or foods which could damage, loosen or dislodge orthodontic appliances need to be avoided. Loosened or damaged orthodontic appliances can be inhaled or swallowed or could cause other damage to the patient. You should inform your orthodontist of any unusual symptoms or of any loose or broken appliances as soon as they are noticed. Damage to the enamel of a tooth or to a restoration (crown, bonding, veneer, etc.) is possible when ortho¬dontic appliances are removed. This problem may be more likely when esthetic (clear or tooth colored) appliances have been selected. If damage to a tooth or restoration occurs, restoration of the involved tooth/teeth by your dentist may be necessary.

Headgear

Orthodontic headgear can cause injury to the patient. Injuries can include damage to the face or eyes. In the event of injury or especially an eye injury, however minor, immediate medical help should be sought. Refrain from wearing headgear in situations where there may be a chance that it could be dislodged or pulled off. Sports activities and games should be avoided when wearing orthodontic headgear.

Temporomandibular (Jaw) Joint Dysfunction

Problems may occur in the jaw joints, i.e., temporomandibular joints (TMJ), causing pain, headaches or ear problems. Many factors can affect the health of the jaw joints, including past trauma (blows to the head or face), arthritis, hereditary tendency to jaw joint problems, excessive tooth grinding or clenching, poorly balanced bite, and many medical conditions. Jaw joint problems may occur with or without orthodontic treatment. Any jaw joint symptoms, including pain, jaw popping or difficulty opening or closing, should be promptly reported to the orthodontist. Treatment by other medical or dental specialists may be necessary.

Impacted, Ankylosed, Unerupted Teeth

Teeth may become impacted (trapped below the bone or gums), ankylosed (fused to the bone) or just fail to erupt. Oftentimes, these conditions occur for no apparent reason and generally cannot be anticipated. Treatment of these conditions depends on the particular circumstance and the overall importance of the involved tooth, and may require extraction, surgical exposure, surgical transplantation or prosthetic replacement.

Occlusal Adjustment

You can expect minimal imperfections in the way your teeth meet following the end of treatment. An occlusal equilibration procedure may be necessary, which is a grinding method used to fine-tune the occlusion. It may also be necessary to remove a small amount of enamel in between the teeth, thereby "flattening" surfaces in order to reduce the possibility of a relapse.

Non-Ideal Results

Due to the wide variation in the size and shape of the teeth, missing teeth, etc., achievement of an ideal result (for example, complete closure of a space) may not be possible. Restorative dental treatment, such as esthetic bonding, crowns or bridges or periodontal therapy, may be indicated. You are encouraged to ask your orthodontist and family dentist about adjunctive care.

Third Molars

As third molars (wisdom teeth) develop, your teeth may change alignment. Your dentist and/or orthodontist should monitor them in order to determine when and if the third molars need to be removed.

Allergies

Occasionally, patients can be allergic to some of the component materials of their orthodontic appliances. This may require a change in treatment plan or discontinuance of treatment prior to completion. Although very uncommon, medical management of dental material allergies may be necessary.

continued on next page

Patient or Parent/Guardian Initials _____

Patient _____ Date _____

Transmission of Disease

Although our orthodontic office is following the State and Federal regulations and recommended universal personal protection and disinfection protocols to prevent transmission of communicable disease, it is possible that that they will not always be successful in blocking the transmission of a highly infectious virus. It is not possible to render orthodontic treatment with social distancing between the patient, orthodontist, assisting staff and sometimes, other patients. Knowing that you could be exposed to communicable diseases anywhere, by presenting yourself or your child for orthodontic treatment, you assume and accept the risk that you may inadvertently be exposed to a communicable disease in the orthodontic office.

General Health Problems

General health problems such as bone, blood or endocrine disorders, and many prescription and non-prescription drugs (including bisphosphonates) can affect your orthodontic treatment. It is imperative that you inform your orthodontist of any changes in your general health status.

Use of Tobacco Products

Smoking or chewing tobacco has been shown to increase the risk of gum disease and interferes with healing after oral surgery. Tobacco users are also more prone to oral cancer, gum recession, and delayed tooth movement during orthodontic treatment. If you use tobacco, you must carefully consider the possibility of a compromised orthodontic result.

Temporary Anchorage Devices

Your treatment may include the use of a temporary anchorage device(s) (i.e. metal screw or plate attached to the bone.) There are specific risks associated with them.

It is possible that the screw(s) could become loose which would require its/their removal and possibly relocation or replacement with a larger screw. The screw and related material may be accidentally swallowed. If the device cannot be stabilized for an adequate length of time, an alternate treatment plan may be necessary.

It is possible that the tissue around the device could become inflamed or infected, or the soft tissue could grow over the device, which could also require its removal, surgical excision of the tissue and/or the use of antibiotics or antimicrobial rinses.

It is possible that the screws could break (i.e. upon insertion or removal.) If this occurs, the broken piece may be left in your mouth or may be surgically removed. This may require referral to another dental specialist.

When inserting the device(s), it is possible to damage the root of a tooth, a nerve, or to perforate the maxillary sinus. Usually these problems are not significant; however, additional dental or medical treatment may be necessary.

Local anesthetic may be used when these devices are inserted or removed, which also has risks. Please advise the doctor placing the device if you have had any difficulties with dental anesthetics in the past.

If any of the complications mentioned above do occur, a referral may be necessary to your family dentist or another dental or medical specialist for further treatment. Fees for these services are not included in the cost for orthodontic treatment.

ACKNOWLEDGEMENT

I hereby acknowledge that I have read and fully understand the treatment considerations and risks presented in this form. I also understand that there may be other problems that occur less frequently than those presented, and that actual results may differ from the anticipated results. I also acknowledge that I have discussed this form with the undersigned orthodontist(s) and have been given the opportunity to ask any questions. I have been asked to make a choice about my treatment. I hereby consent to the treatment proposed and authorize the orthodontist(s) indicated below to provide the treatment. I also authorize the orthodontist(s) to provide my health care information to my other health care providers. I understand that my treatment fee covers only treatment provided by the orthodontist(s), and that treatment provided by other dental or medical professionals is not included in the fee for my orthodontic treatment.

CONSENT TO UNDERGO ORTHODONTIC TREATMENT

I hereby consent to the making of diagnostic records, including x-rays, before, during and following orthodontic treatment, and to the above doctor(s) and, where appropriate, staff providing orthodontic treatment prescribed by the above doctor(s) for the above individual. I fully understand all of the risks associated with the treatment.

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I hereby authorize the above doctor(s) to provide other health care providers with information regarding the above individual's orthodontic care as deemed appropriate. I understand that once released, the above doctor(s) and staff has(have) no responsibility for any further release by the individual receiving this information.

TRANSFERRING PATIENT

Orthodontic treatments vary widely. Transfer will likely increase treatment fees, may involve changes in payment policies, and may change your treatment and/or appliances. When you transfer to a new orthodontist, your treatment time is often extended by the process of transfer.

Notes

_____

Signature of Patient/Parent/Guardian Date

_____

Signature of Orthodontist/Group Name Date

_____

Witness Date

I have the legal authority to sign this on behalf of

_____

Name of Patient

_____

Name of Parent/Guardian

_____

Relationship to Patient

CONSENT TO USE OF RECORDS

I hereby give my permission for the use of orthodontic records, including photographs, made in the process of examinations, treatment, and retention for purposes of professional consultations, research, education, or publication in professional journals.

_____

Signature Date

_____

Witness Date

RICKABAUGH
ORTHODONTICS

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

(copy of HIPAA notice located in Reception Area)

I have been offered a copy of Jeff L. Rickabaugh, DDS,MDS,PA Notice of Privacy Practices; detailing how my health information may be used and disclosed as permitted under federal and state law.
I understand the contents of the Notice.

With Whom may we discuss your payment (i.e. parents, stepparents, ins, etc.)

_____

_____

_____

_____

Patient/Guardian signature **Date**

*****IF NOT SIGNED BY PATIENT, PLEASE INDICATE RELATIONSHIP TO PATIENT*****

_____

Relationship to Patient **Guardian DOB**

_____

EXTERNAL USE ONLY

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to the patient to sign below.

_____

Presented on: Date/time By: (Name and Title)

RICKABAUGH ORTHODONTICS

"Practice Limited to Orthodontics"

Social Media and Photographic Consent Form

I, _____ (patient giving consent and/or parent/guardian if under 18 years old age) hereby consent to the collection and use of my personal images by photography or video recording for use on Jeff L Rickabaugh DDS PA social media pages. I understand only first names will be posted with any photography or video posted containing personal images. I also understand that my consent can be withdrawn at any time via written request to Jeff L Rickabaugh DDS PA at 1551 Westbrook Plaza Drive, Suite 103, Winston Salem, NC 27103.

☐ I give consent

☐ I decline consent

_____

Patient Name (please print)

_____ _____

Patient / Guardian if under 18 Sign Date