ORTHODONTIC PATIENT INFORMATION ACQUAINTANCE FORM

Welcome to our office,

The following information is requested to enable us to give you the best consideration for your orthodontic problem during your initial examination in our office. In order for the Doctor to thoroughly diagnose any condition, he must have accurate background and health information on which to base his decisions. This information, important for our records and your health, is confidential. Please circle the appropriate response where indicated.

Thank you

Patient's Last Name ____ First ____ Nickname ____

Home Phone No. ( ) ____

Birthdate ____ Age - Yr. ____ Mo. ____ Sex ____

School ____ Phone No. ( ) ____ Grade ____

Hobbies ____

Referred By ____ Address ____

Employer ____ Insurance ____

Group ____ Sub. ____

Ann. Date ____ Ortho Cov. ____ Max. ____ % ____

Father's/ Husband's Name ____ Occupation ____

Address (If Different) ____

Employed By ____ Bus. Telephone ( ) ____

Business Address ____

Mother's/ Wife's Name ____ Occupation ____

Employed By ____ Bus. Telephone ( ) ____

Business Address ____

Names & Ages of Other Children In Family ____

Person Responsible For This Account ____

Credit References: Name ____ Address ____

Name ____ Address ____

Family Status ____

Family Dentist ____ Phone No. ( ) ____ Family Physician ____ Phone No. ( ) ____

Other Family Members With Similar Orthodontic Condition?

Father Brother Other

Mother Sister Specify ____

Patient's Marital Status

Patient Living With: Mother Father Self Other: ____

MEDICAL & DENTAL HISTORY:

Present Health: Good Fair Poor Under Treatment: Yes ☐ No ☐

Specify: ____

Present Drugs or Medication, or Mineral, or Vitamins: Yes ☐ No ☐

Specify: ____

Has patient been under care of Physician during the past two years other than for routine examination? Yes ☐ No ☐

Birth Defects Yes ☐ No ☐

Specify: ____

Has patient reached puberty (menstruation, hair, voice change)? Yes ☐ No ☐

Height ____ Weight ____

Has the patient ever had:

Asthma	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐	Liver Disorder (Hepatitis)	Yes ☐	No ☐
Anemia	Yes ☐	No ☐	Epilepsy	Yes ☐	No ☐	Heart Disease	Yes ☐	No ☐
Blood Disease (Prolonged Bleeding)	Yes ☐	No ☐	Endocrine Problems	Yes ☐	No ☐	Head or Face Injury	Yes ☐	No ☐
Bone Disorders	Yes ☐	No ☐	Emotional Problems	Yes ☐	No ☐	Rheumatic Fever	Yes ☐	No ☐
Fainting or Dizzy	Yes ☐	No ☐	Hearing Disorder	Yes ☐	No ☐	Kidney Involvement	Yes ☐	No ☐

Comments: ______________________________

Does the patient:

1. Have allergies to: Seasonal Grass ______ Food ______
   Drugs ______ Other ______
2. Snore when sleeping? Yes ☐ No ☐
3. Breath through mouth? Seldom Sometimes Usually Comments: ______
4. Have frequent colds? Yes ☐ No ☐
5. Have frequent sore throat or tonsillitis? Yes ☐ No ☐
6. Have chewing or swallowing difficulty? Yes ☐ No ☐

Has the patient received medical treatment from allergist or ear, nose and throat specialist?
Yes ☐ No ☐ If YES: When ______ When ______
Tonsils removed ______ Tonsils removed ______
Use of Nasal Spray ______ Use of Nasal Spray ______

Does the patient have pain or clicking in jaw joint? Yes ☐ No ☐

Have any teeth been injured due to accidents or blows to the mouth? Yes ☐ No ☐

Has the patient received or been requested to receive speech correction? Yes ☐ No ☐

The following habits are of interest to the Doctor. List information as it pertains to this patient:

Thumb sucking until age ______ Grinding of teeth Yes ☐ No ☐
Finger sucking until age ______ Tongue thrusting Yes ☐ No ☐
Lip-biting or sucking Yes ☐ No ☐ Other habits Yes ☐ No ☐

Has the patient had any unusual dental experiences? Yes ☐ No ☐
Specify: ______

Has the patient had previous orthodontic consultation or treatment? Yes ☐ No ☐
Date: ______ Dr.: ______

Are there any other medical, dental or surgical problems not covered above? Yes ☐ No ☐

PATIENT'S ATTITUDE TOWARD TEETH, FACE AND ORTHODONTIC TREATMENT:

Dental checkups: Twice A Year Once A Year Only If Urgent Never

Date of last dental checkup ______ Were the patient's teeth cleaned? Yes ☐ No ☐

Is the patient aware of any orthodontic problem? Yes ☐ No ☐

Patient's interest in orthodontic treatment: The Patient Wants Treatment Treatment If Necessary Unwilling But Agrees Uncooperative

Patient's consultation prompted by: Patient Dentist Mother Father Spouse Sibling Physican Friend
Other (specify): ______

Why did the patient seek this consultation? ______

What is the Primary Problem? ______

What is expected from orthodontic treatment? ______

Additional comments you wish to make: ______

SIGNATURE OF INDIVIDUAL COMPLETING THIS FORM: ______

Relationship to Patient ______ Today's Date ______

GENERAL RELEASE

I the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical-dental history. I realize that the Dentist is a general practitioner who offers orthodontic treatment to patients. Should there be any change in my health status in the future, I will advise this dental office. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my doctor or another health care provider may be necessary, and I consent to the responsibility for payment of the dental services for myself and my dependants is mine solely, and I assume responsibility for fees associated with these services. Our office requires three working days notification, should you be unable to keep the scheduled appointment time. There is a minimum charge for missed appointments..

X ______ ______
(signature) Parent / Guardian (print name)

Reviewed by Treating Dentist ______ Date ______

CONSENT

______________________________ for orthodontic treatment of ______________________________
DATE

IN THE VAST MAJORITY OF ORTHODONTIC CASES IMPROVEMENTS CAN BE ACHIEVED. WHILE THE BENEFITS OF A PLEASING SMILE AND HEALTHY TEETH ARE WIDELY APPRECIATED, ORTHODONTIC TREATMENT REMAINS AN ELECTIVE PROCEDURE. IT, LIKE ANY OTHER TREATMENT OF THE BODY, HAS SOME INHERENT RISK AND LIMITATIONS. THESE SELDOM PREVENT TREATMENT, BUT SHOULD BE CONSIDERED IN MAKING THE DECISION TO UNDERGO TREATMENT.

LACK OF PATIENT CO-OPERATION- MOST COMMON CAUSE FOR EXCESSIVE TREATMENT TIME
Lack of or undesirable growth, insufficient wearing of elastics or retractor (headgear), broken appliances and MISSED APPOINTMENTS are important factors which can lengthen time and adversely affect the quality of treatment.

RETRACTOR (HEADGEAR)- INSTRUCTIONS MUST BE FOLLOWED CAREFULLY
If pulled out while the elastic force is attached, it can snap back and cause injury.

DECALCIFICATION- PERMANENT TOOTH DISCOLORATION
Excellent oral hygiene, reduction of sugar intake and reporting any loose bands as soon as noticed, will help minimize decay and gum problems.

NONVITAL OR DEAD TOOTH- TOOTH TRAUMATIZED BY A BLOW OR OTHER CAUSES
A traumatized tooth can die over a period of time with or without orthodontic treatment. This tooth may flare up during orthodontic movement and require endodontic treatment (root canal).

IMPACTED TEETH- TEETH UNABLE TO ERUPT NORMALLY
In attempting to move impacted teeth, especially cuspids, various problems are sometimes encountered which may lead to loss of the tooth or periodontal problems.

ROOT RESORPTION- SHORTENING OF ROOT ENDS
This can occur with or without orthodontic treatment. Under healthy conditions the shortened roots usually are no problem. Trauma, cuts, impaction, endocrine disorders or idiopathic reasons can also cause this problem.

TEMPOROMANDIBULAR JOINTS (TMJ)- SLIDING HINGE CONNECTING THE UPPER AND LOWER JAWS
Possible problems may exist or occur during orthodontic treatment. Tooth position and bite can be a factor in this condition. An equilibration, by your dentist may be recommended after appliances are removed to improve occlusal relationship.

GROWTH PATTERNS- FACIAL GROWTH OCCURRING DURING OR AFTER TREATMENT
Bad habits, unusual skeletal patterns and insufficient or undesirable growth can compromise the dental results, effect a facial change and cause shifting of teeth during retention. Surgical procedures frequently can be used to counter these problems

POST TREATMENT TOOTH MOVEMENT- RELAPSE
There is a likelihood that teeth will shift or settle after treatment as well as after retention. Some change may be desirable, but others will not. Rotations and crowding of the lower anterior teeth are the most common examples. Slight spaces in the extraction site or between the upper centrals are other examples.

UNUSUAL OCCURRENCES- SWALLOWING APPLIANCES, CHIPPING TEETH, DISLODGING RESTORATIONS

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 DO REALIZE THE RISKS AND LIMITATIONS INVOLVED, AND DO CONSENT TO ORTHODONTIC TREATMENT.

____
PATIENT - PARENT - GUARDIAN

____
WITNESS

ACKNOWLEDGMENT OF CONSENT

I, the undersigned, certify that I have been fully informed as to the treatment and alternative treatment plans available, and have been advised of the consequences of not accepting the treatment plans as presented. I have also been informed of the material effects, risks and side effects due to existing medical-dental conditions. I have had the opportunity to ask questions relating to the treatment and any specific medical-dental condition. I realize that the dentist is a general practitioner who offers orthodontic treatment to his patients. I wish to proceed with the selected treatment plan and take responsibility for payment of the fees associated with these services.

X______________________________ ______________________________
Patient / Parent / Guardian

INFORMED CONSENT: Orthodontic Treatment

Dear Patient,

We are delighted that you have entrusted us with your orthodontic care. We shall do our utmost to uphold that trust by offering the best possible treatment we are capable of providing. The optimum results are usually achieved with well-informed and thus cooperative patients.

We ask you to read the following to share with you some facts about orthodontic treatment, which, like any medical or dental procedure, may include some limitations. This information is routinely supplied to anyone considering orthodontic treatment in our office. That is, it helps to provide information regarding what one may expect from treatment and to point out potential risks that may be encountered during or after treatment. As well, it provides enough information so that the patient has an understanding of the extent of the problem, benefits from the treatment, risks of treatment, treatment alternatives and possible consequences if no treatment is performed.

PATIENT COOPERATION

It is imperative that the patient keep scheduled appointments, practice excellent oral hygiene (we highly recommend the *SONICARE*), wear appliances as prescribed, eat proper foods, and wear retainers after active treatment.

_____ Initial

CAVITIES, SWOLLEN GUMS, WHITE SPOTS

Orthodontic appliances do not cause cavities, swollen gums or white spots but they can set up an environment in which these negatives things can occur if excellent oral hygiene practices are not met. We recommend the use of the *SONICARE* and regular check-ups to help ensure that this does not occur.

_____ Initial

LOSS OF TOOTH VITALITY

This can occur with or without orthodontic treatment. This is usually associated with teeth that had a previous injury, or have a large/deep filling. Root canal therapy would then be required.

_____ Initial

DISCONTINUANCE OF TREATMENT

Treatment will be discontinued for lack of patient cooperation, including poor oral hygiene, broken appliances, lack of wear time of appliance or elastics and in case where, to continue the treatment, would unfavourably influence the dental health of the patient. Prior to discontinuance of treatment, the patient or parent will be thoroughly informed of the reasons and hopefully will agree.

_____ Initial

RELAPSE

Relapse is defined as the movement or shifting of the teeth back to their original position after the braces have been removed. Minor relapse can occur even with good cooperation throughout the active and retention phases of treatment. Some contributing factors may include eruption of wisdom teeth, the growth pattern of the jaws (direction and amount), muscle balance (lips, cheeks and tongue) and habits. It is important for patients to keep their appointments during the retention stage and to wear their retainers at all times, except while engaged in contact sports or cleaning the appliance.

_____ Initial

BRACKET PLACEMENT

When using brackets, it is possible that some of the tooth's enamel may be removed inadvertently if the tooth has enamel fracture lines or if the occlusion shears off a bracket.

_____ Initial

ALLERGIC REACTIONS

Allergies to medicines and orthodontic materials may occur during orthodontic treatment. If you are aware of these allergies they can be avoided, but if they are unknown to you, it is impossible to predict any reaction. People who are already allergic to certain foods, or who have hay fever, are more prone to allergies to orthodontic materials.

_____ Initial

PRECAUTIONS

Sometimes orthodontic appliances may be accidentally swallowed or aspirated, or may irritatate or damage the oral tissue. Also, *if improperly handled,* headgear may cause injury to the face or eyes or even blindness. Although, if the patient is careful and follows the instructions given, the possibility of such a mishap is extremely rare.

_____ Initial

ROOT RESORPTION

This can occur with or without orthodontic treatment in some individuals. This negative side effect usually present no problems for patients with normal root length and healthy gums and bone. If the patient has gum disease with resultant loss of supporting bone, then root resorption can cause the tooth to be lost sooner.

_____ Initial

UNFAVOURABLE GROWTH

In the case of younger, growing patients, the treatment plan will be determined on the anticipated amount and direction of facial growth. On occasion, the facial growth does not occur as predicted and a change in treatment objectives and procedures may be necessary. Growth is an inherited biological process, and is beyond the dentist's control. Thumb, finger or tongue habits and mouth breathing can adversely affect growth. My philosophy is to treat problems early and non-surgically, if possible.

_____ Initial

TMJ (JAW JOINT)

Some patients experience TMJ problems prior to, during, and after orthodontic treatment. Some of the signs and symptoms include; clicking, popping, limited mobility, and possibly pain and locking of the jaw in serious cases. During the records appointment, we attempt to determine the presence and severity of TMJ problems, and then minimize risks during treatment.

_____ Initial

ENAMEL REDUCTION

Reshaping the tooth (limited to enamel) before, during or after treatment, may be recommended to provide room for alignment, improved appearance and stability.

_____ Initial

TOOTH SIZE DISCREPANCY

If after orthodontic treatment minor spacing remains between the teeth because of small or abnormal tooth size, bonding (white filling material) may be suggested to fill the spaces. This improves the esthetics and stability of the case.

_____ Initial

TREATMENT TIME

This can vary with the severity of the malocclusion, patient cooperation, and individual response to the orthodontic treatment. Lack of projected facial growth and growth direction, poor patient compliance, broken appliances, or missed appointments all lengthen treatment time and may also effect the final result. Normal treatment time with braces is 24-30 months, but this can vary considerably and does not include Phase 1 or the orthopaedic phase of treatment.

_____ Initial

Informed Consent-Extra

Impacted Teeth (Teeth under the gums and bone)
☐Tooth may not erupt (even with help)
☐May erupt with periodontal (gum) problems
☐ May erupt with pulp (nerve) problem
☐Surgery to uncover may damage roots of adjacent teeth
☐Roots of adjacent teeth may already be damaged
Class II (Upper teeth-jaws protruded &/or lower teeth-jaws retruded)
☐May not correct with braces alone
☐May need additional appliances
☐May need upper extractions
☐May need orthognathic surgery
☐May have compromised results
Class III (Upper teeth-jaws retruded &/or lower-jaws teeth protruded)
☐May not correct with braces alone
☐May need lower extractions
☐May need orthognathic surgery
☐May have compromised results
Open Bites
☐May not correct with braces alone
☐May need orthognathic surgery
☐May have compromised results
Deep Bites
☐May not correct with braces alone
☐May need orthognathic surgery
☐May have compromised results
Asymmetries (Arches not proportional with each other)
☐May not correct with braces alone
☐May need orthognathic surgery
☐May have compromised results
Crossbites
☐May not correct with braces alone
☐May need additional appliances
☐May need orthognathic surgery
☐May have compromised results

☐Remember without full patient cooperation the results will be compromised

______________________ __________________

Signature of Guardian Date

OUR TREATMENT GOALS – THE BEST TREATMENT POSSIBLE

We strive to provide the optimal result possible. Orthodontics is not a perfect science and in dealing with growth and development, genetics, and patient cooperation, achieving a 'perfect' result is not always possible. No guarantees can be given as to the orthodontic finished result, as the majority of factors are beyond the dentist's control.

PROPOSED TREATMENT PLAN

a) Active Treatment

Phase 1 ______________________________

Phase 2 ______________________________

Phase 3 ______________________________

b) Retention Phase

____

QUALIFICATIONS

I acknowledge that Dr. V. Sun is not an orthodontist, but rather a general dentist who has taken numerous post graduate courses in orthodontics.

Dr. V. Sun attempts to stay abreast of all the newer techniques in all phases of dentistry, including orthodontics, in an effort to provide the best possible treatment to his patients.

PERMISSION TO USE PHOTOGRAPHS & X-RAYS

I consent to the taking of photographs and x-rays before, during, and after orthodontic treatment, as they are necessary part of the diagnostic procedure and record keeping. I further give permission for the use of these photographs, x-rays and records to be used for the purpose of research, education, or publication in professional journals.

UNDERSTANDING INFORMATION AND INFORMED CONSENT DOCUMENT

I certify that the general treatment considerations and the potential problems of orthodontic treatment were presented to me and that I have read and understand the contents; including benefits of treatment, risks of treatment and non-treatment, and the proposed orthodontic treatment plan. I now consent to treatment.

REVIEWED BY:

____
Patient/Parent Signature

____
Date

____

Victor Sun Dentistry Professional Corporation
4 Russell St. E.
Lindsay, Ont.
K9V 1Z6
Tel: 705-324-0050

PATIENT/ PARENT RESPONSIBILITIES FOR ORTHODONTIC TREATMENT

1. No sticky, chewy, hard foods. ________
Initial

2. Chronic, poor oral hygiene will lead to immediate removal of appliances without reimbursement for past services rendered. ________
Initial

3. Cleaning or Prophylaxis: You must have your teeth cleaned and examined so that we can ascertain that the supporting structures (bone and gum) are healthy. If you have had your teeth cleaned within the last 6 months, this will be acceptable. Professional cleaning visits are necessary every 3 months with your hygienist during Orthodontic treatment.

____
Initial

4. Brackets must remain on the teeth for treatment to continually progress. If brackets continually come off due to negligence by the patient, then a fee will apply to have the brackets re-cemented. ________
Initial

5. If extractions are required, they are additional cost to the treatment plan. ________
Initial

6. Appliances that are lost are to be replaced at the cost of the patient. ________
Initial

7. If at any time your financial arrangement is broken with Dr. Victor Sun's dental office, it will result in the immediate removal of the Orthodontic appliance and treatment will be discontinued. ________
Initial

Signature______________________________
Patient's name: ______________________ Date:

Signature______________________________
Parent/Guardian name: ______________________ Date: