San Martín
ORTHODONTICS

Welcome to San Martín Orthodontics. Please fill out this form as best as you can.

Would you be comfortable with a Therapy Dog in the office at your appointment? ____ Yes ____ No

About You

Name: ____________________________________
Mr. / Mrs. / Ms. / Miss / Dr.

Preferred name: ____________________________

SS#: ____ - ____ - ________ [ ] male [ ] female

Date of Birth: ______ / ______ / ______ Age: _______

Email: ____________________________________

[ ] Single [ ] Married [ ] Divorced

[ ] Widowed [ ] Separated

Home address: ____________________________

____
city state zip

Home #: ____________________
Cell #: ____________________
Work #: ____________________ Ext: ______
Employer: __________________________________
How long there: _____ Occupation: ____________

How did you hear about us? ____________________

____

General dentist: ____________________________
Last visit: ____________________

Insurance

PRIMARY

Orthodontic coverage: [ ] yes [ ] no
Dental coverage: [ ] yes [ ] no

Insurance company: __________________________
Address: ___________________________________

____

Phone: (_____) _____ - __________
Member ID #: ________________
Insured's Name: ____________________________
Relation: _______________
Insured's DOB: ______ / ______ / ______
Insured's SS#: ____ - ____ - ________
Insured's Employer: __________________________

SECONDARY

Orthodontic coverage: [ ] yes [ ] no
Dental coverage: [ ] yes [ ] no

Insurance company: __________________________
Address: ___________________________________

____

Phone: (_____) _____ - __________
Member ID #: ________________
Insured's Name: ____________________________
Relation: _______________
Insured's DOB: ______ / ______ / ______
Insured's SS#: ____ - ____ - ________
Insured's Employer: __________________________

About Your Spouse

His/Her name: ______________________________
Employer: __________________________________
Phone #: __________________ Date of Birth: _______

Emergency Contact

Name: ____________________________________
Phone #: __________________________________
Relation: __________________________________

MEDICAL HISTORY

Do you have a personal physician: [ ] yes [ ] no

Physician or Practice's name: ______________________

Phone #: ______________________ Last visit: __________

Your current health is: [ ] good [ ] fair [ ] poor

Are you currently under the care of a physician?

[ ] yes [ ] no

Please explain: ______________________

Are you taking any prescription or OTC drugs?

[ ] yes [ ] no

Please list: ______________________

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

Yes	No	
[ ]	[ ]	Abnormal bleeding
[ ]	[ ]	Heart surgery / pacemaker
[ ]	[ ]	Artificial bones / joints / valves
[ ]	[ ]	Asthma / Arthritis
[ ]	[ ]	Blood transfusion
[ ]	[ ]	Cancer / Chemotherapy
[ ]	[ ]	Congenital heart defect
[ ]	[ ]	Diabetes / Tuberculosis (TB)
[ ]	[ ]	Difficulty Breathing
[ ]	[ ]	Drug / Alcohol abuse
[ ]	[ ]	Emphysema / Glaucoma
[ ]	[ ]	Epilepsy / Seizures / Fainting
[ ]	[ ]	Fever blisters / Herpes
[ ]	[ ]	Heart attack / Stroke
[ ]	[ ]	Heart Murmur
[ ]	[ ]	Hemophilia
[ ]	[ ]	Hepatitis
[ ]	[ ]	High / Low blood pressure
[ ]	[ ]	HIV+ / AIDS
[ ]	[ ]	Hospitalizations for any reason
[ ]	[ ]	Kidney problems
[ ]	[ ]	Mitral valve prolapse
[ ]	[ ]	Psychiatric problems
[ ]	[ ]	Rheumatic / Scarlet fever
[ ]	[ ]	Severe / Frequent headaches
[ ]	[ ]	Shingles
[ ]	[ ]	Sinus problems
[ ]	[ ]	Ulcers / Colitis
[ ]	[ ]	Venereal disease

Please list any serious medical conditions that you have ever had: ______________________

ALLERGIES

Are you allergic to any of the following?

Yes	No	
[ ]	[ ]	Aspirin
[ ]	[ ]	Latex
[ ]	[ ]	Codeine
[ ]	[ ]	Dental anesthetics
[ ]	[ ]	Erythromycin
[ ]	[ ]	Penicillin
[ ]	[ ]	Tetracycline
[ ]	[ ]	Any metals or plastics: ______________
[ ]	[ ]	Other ______________

DENTAL HISTORY

What is the main reason why you are seeking orthodontic treatment? ______________________

____

Have you or anyone in your family ever had JAW SURGERY?______________________

Have you ever been evaluated for braces? _______

Have you ever had a problem with any previous dental work? ______________________

Do you now or have you ever experienced pain in your jaw joint (TMJ/TMD)? ______________________

Your dental health is: [ ] good [ ] fair [ ] poor

Do your gums bleed? [ ] yes [ ] no

Any injury to the mouth/jaw? [ ] yes [ ] no

Do you have speech problems? [ ] yes [ ] no

Do you generally breathe through their mouth:

while awake? [ ] yes [ ] no

while asleep? [ ] yes [ ] no

Any missing or extra teeth? [ ] yes [ ] no

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

____

Signature Date

Informed Consent

Potential Risks and Limitations of Orthodontic Treatment

As a rule, excellent orthodontic results can be achieved with informed and cooperative patients. Thus, the following information is routinely supplied to anyone considering orthodontic treatment in our office. The benefits of orthodontic treatment include achieving a pleasing smile and a functional bite. You should also be aware that orthodontic treatment, like any treatment of the body, has some inherent risks and limitations. These drawbacks seldom outweigh the long term benefits, but should be considered in making the decision to have orthodontic treatment.

Excellence is always our goal. The orthodontist will use his knowledge, training, skills, and experience to achieve proper function that is also esthetically pleasing; however, much depends on the patients growth pattern, genetics, oral health, and cooperation.

Throughout life, tooth positions constantly change. This is true with all individuals regardless of whether they have worn braces or not. After treatment, orthodontic patients are subject to the same subtle changes that occur in non-orthodontic patients. Orthodontic patients may notice slight irregularities develop especially in the area of the front teeth. This is particularly true if their teeth were extremely crowded prior to treatment. Continued use of a retainer may be the only way to prevent this.

Decalcifications (permanent white spots), tooth decay, or gum disease can occur if patients do not brush and floss their teeth properly. Excellent oral hygiene and daily plaque removal are essential. Sugars and between-meal-snack should be avoided. Regular check-ups with the family dentist are necessary to check for decay and to thoroughly clean the teeth. Occasionally, periodontal (gum) problems present before orthodontic treatment may worsen by the wearing of braces and require treatment by another dental specialist.

Cold sores, canker sores, irritation and/or injury to the mouth are possible while wearing braces. Allergic reactions to dental materials or medications are rare, but do occur occasionally. There may be the need for extractions of teeth, fillings, crowns, bridges, gum treatment, or other dental procedures before, during, or after orthodontic treatment. If necessary, this will be performed by another dentist.

On rare occasions the nerve of a tooth may become non-vital or abscessed. A tooth that has been irritated by a deep filling or even a minor blow may flare-up over time, with or without orthodontic treatment. A non-vital tooth may require root canal treatment and a crown by another dentist.

In some cases, the root ends of the teeth are shortened during treatment. This is called root resorption. Under healthy circumstances the shortened roots are of no disadvantage. However, in the event of gum disease, the root resorption could reduce the longevity of the affected teeth. It should be noted that root resorption can occur unrelated to orthodontic treatment.

There is also a risk that problems may occur in the temporomandibular joints (TMJ). Tooth alignment or bite correction can usually improve tooth-related causes of TMJ discomfort, but additional treatment by another dentist may be required.

Occasionally, a person who has grown normally and in average proportion may not continue to do so. If growth becomes disproportionate, the jaw position can be affected and original treatment objective may have to be compromised. Skeletal growth disharmony is a biological process beyond the orthodontist's control.

Orthodontic treatment can succeed only through the combined cooperation of all parties involved. Together, we can achieve the best possible result. In many instances, lack of cooperation with the requested use of elastics, or broken appliances will lengthen the treatment time and make successful completion of treatment impossible. Because most of our patients are of school age, it is essential that some appointments be scheduled during school hours.

We appreciate your confidence in selection our office. We want you to be fully informed, so feel free to ask questions at any time. During the period of orthodontic treatment, we will make models, x-rays, and photographs which may be used for professional reference and display, orthodontic journals, books, meetings, and/or patient education.

I have read and understand this form and consent to treatment for ____

Signature ______________________________ Date ______________ Relationship _________________________

Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

Your protected health information (i.e. individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleaning, surgery, etc.);
- To third party payers or spouses (i.e. insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e. to determine benefits, dates of payments, etc.);
- To certifying, licensing and accrediting bodies (i.e. the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in your treatment;
- To other patients and third parties who may or see or overhear incidental disclosures about your treatment, scheduling, etc.;
- To your family and close friends involved in your treatment; and/or,;
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosure of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:
- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights by submitting inquiries to our Privacy Contact Person at our office address or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:
- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect;
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:
- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, Please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

Patient Acknowledgement

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED AND REVIEWED A COPY OF THIS PRIVACY NOTICE.

____

Patient Signature Date

Photography Privacy Notice

THIS NOTICE DESCRIBES HOW SOME OF THE RECORDS, PHOTOS SPECIFICALLY, COULD BE USED.

Dr. San Martín is extremely proud of his patients and their orthodontic progress. Before and after photographs of smiles and teeth allow us to showcase what is possible with braces and/or Invisalign. On social media and on our website's Smile Gallery, Dr. San Martín would like to post these photographs from time to time for potential patients to see. Be aware that:

- Your protected health information (i.e. individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) <u>WILL NOT</u> be shown on the website. In fact, aside from indicating "initial" or "final" photos, there is zero information about you or your child that will be shown.
- Not everyone's photos will be used.
- There is absolutely no pressure to agree, and it is entirely up to you to decide whether or not you would like the photographs to be posted in this way.
- At any time, if you would like to remove your or your child's photographs from the site, we will do so as soon as possible.

Please indicate your choice:

_____ YES, I would allow Dr. San Martín to post my photographs.

_____ NO, I would prefer if my photographs were not used.

<u>Patient Acknowledgement</u>

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED AND REVIEWED A COPY OF THIS PRIVACY NOTICE.

______________________________________ ______________________________________
Patient Relationship

______________________________________ ______________________________________
Signature Date