



Dr. Charles Stewart, D.D.S.
 1429 Clear Lake, Suite 300
 Weatherford, TX 76086
 (817) 341-2777
www.stewartortho.com

PATIENT HEALTH HISTORY

Patient Last Name		First Name		M.I.	Patient Date of Birth		Patient SSN	
Address			City		State		Zip	Phone
Party Responsible or Guardian		Phone		Email		DL# Rep Party		SSN of Rep Party
Employer Name				Position			Business Phone	
Nearest Relative not living with you			Address			Phone		Relationship
Dental Insurance No. 1		Group No.		Company Name		Policy Holder		SSN
Dental Insurance No. 2		Group No.		Company Name		Policy Holder		SSN

I authorize release of any information necessary to process dental claim. I hereby authorize payment directly to the below-named Dentist of the Group Insurance Benefits otherwise payable to me.

Signed (patient or parent if minor) _____ Date _____ Signed (insured person) _____ Date _____

Referred By: Friend Dentist Yellow Pages Other: _____

Marital Status: _____ Name of general dentist: _____ Date of Last Dental Exam & Cleaning: _____

- Yes No Have you ever had any of the following:**
- Hepatitis
 - Liver Disease
 - Epilepsy convulsions
 - Seizures
 - Rheumatic Fever
 - Kidney Disease
 - Bladder Disease
 - Diabetes
 - Tuberculosis
 - Emphysema
 - Asthma
 - Shortness of Breath
 - Swollen Ankles
 - Chest Trouble
 - High/Low Blood Pressure
 - Stroke
 - Thyroid Trouble
 - Psychiatric Treatment
 - Arthritis
 - Rheumatism
 - Venereal Disease
 - Glaucoma
 - Chemotherapy/Radiation
 - Sinus Problems/Hay Fever/Allergies
 - Problem at Birth
 - Heart Murmur
 - Sickle Cell Anemia
 - Bleeding/ Hemophilia
 - Blood Transfusion
 - AIDS or HIV Positive
 - Cancer
 - Cleft Lip/Palate
 - Speech Problems
 - Hearing Problems
 - Eye Problems/ Contact Lenses
 - Tonsil/Adenoid Problems

- Yes No If you are female, are you:**
- Pregnant
 - Taking Birth Control Pills
 - Taking Hormone Medication
- Circle either Yes or No**
- Are you presently under the care of a physician?
YES / NO if yes, for what and date of last office appointment:

- Have you ever been told that you are allergic to a drug?
YES / NO or have you ever had a bad reaction to a drug?
YES / NO if yes, to either, which drug?

- Have you ever had a bleeding problem?
YES / NO
- Have you ever had trouble with an extraction?
YES / NO if yes to either, please explain.

- Are you presently taking any Drugs or Medications?
YES / NO If yes, please list:

- Yes No**
- Do you have difficulty in opening your mouth widely?
 - Have you ever received a severe blow to your head or jaw?
 - Does it cause pain to open your jaw widely?
 - Do you ever hear popping or clicking sounds from your jaw joints?
 - Are you presently in any pain from your jaw joints or muscles?
 - Are you taking any tranquilizers, muscle relaxants, or antidepressants?

What is the main problem that brought you to our office?

Please add anything about your medical or dental history you feel is important for us to know about:

Doctor's Signature: _____ Date: _____

CONSENT

For orthodontic treatment of _____ Date _____

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.

PREDICTABLE FACTORS THAT CAN AFFECT THE OUTCOME OF ORTHODONTIC TREATMENT:

COOPERATION: 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.

CARING for APPLIANCES – Poor tooth brushing increases the risk of decay when wearing braces. Excellent oral hygiene, reduction in sugar, being selective in diet and reporting any loose bands as soon as noticed, will help minimize decay, white spots (decalcification) and gum problems. Routine visits (3 – 6 months) to your dentist for cleaning and cavity checks are necessary.

WEARING RETRACTOR (headgear) and ELASTICS – These are forces placed on teeth so they will move into their proper positions. The amount of time worn affects results. Wear as instructed! If headgear is detached from the tubes or arch wire hooks while the elastic force is engaged, it can snap back and cause injury.

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 trusting (abnormal swallowing) and other unusual habits can prevent the teeth from moving to their corrected positions or relapse after braces are removed. Orthodontics may deprogram the bite and the bite may become worse with orthodontic treatment.

FACIAL GROWTH PATTERNS – Unusual skeletal patterns and insufficient or undesirable facial growth can compromise the dental results, affect a facial change and cause shifting of teeth during retention. Surgical assistance may be recommended in these situations.

POST TREATMENT TOOTH MOVEMENT – Teeth have a tendency to shift or settle after treatment, as well as after retention. Some changes are desirable, others are not. Rotations and crowding of the lower anterior teeth or slight space in the extraction site or between the upper centrals are common examples.

TEMPOROMANDIBULAR PROBLEMS (TM) – Possible TM problems may develop with this sliding joint on which the lower jaw moves either before, during or after orthodontic treatment. Tooth position, bite or non-symptomatic, pre-existing TM problems can be a factor in this condition. An equilibration (selective smoothing or reshaping the tooth) or other special treatment may be recommended by your dentist to improve occlusal or joint relationship.

IMPACTED TEETH – In attempting to move impacted teeth (teeth unable to erupt normally), especially cuspids and third molars (wisdom teeth), various problems are sometimes encountered which may lead to periodontal problems, relapse, or loss of teeth.

ROOT RESORPTION – Shortening of root ends can occur when teeth are moved during orthodontic treatment. Under healthy conditions the shortened roots usually are no problem. Trauma, impaction, endocrine disorders or idiopathic (unknown) reasons also cause this problem. Severe resorption can increase the possibility of premature tooth loss.

NONVITAL OR DEAD TOOTH – A tooth traumatized by a blow or other causes can die over a long period of time with or without orthodontic treatment. This tooth may discolor or flare up during orthodontic movement and require endodontic treatment – (root canal).

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 prophylaxis by your dentist can help control this situation.

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



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ORTHODONTIC INSURANCE INFORMATION

Please bring your insurance card and know your orthodontic coverage prior to your appointment or it may delay the filing of your insurance benefit. Call your Insurance carrier or Human Resources representative with any questions.

PATIENT INFORMATION:

Patient's First Name: M.I.: Last Name:
Date of Birth (MM/DD/YYYY): Sex: Male Female
Relationship to the Insured: Self Child Spouse Other:

NOTE: If you have a 2nd Insurance in effect at the time of your consult, and it is not presented at that time; it may result in a contract change (higher or lower) which could result in a change to your monthly payment.

SUBSCRIBER INFORMATION:

Subscriber's First Name: M.I.: Last Name:
Address:
City: State: Zip Code:
Subscriber Identifier (SSN or ID#): Date of Birth (MM/DD/YYYY):
Employer Name:
Employer City: Employer Phone Number:

INSURANCE INFORMATION:

Insurance Carrier:
Mailing Address:
City: State: Zip Code:
1-800 Phone Number of Insurance Co.:
Plan/Group Number: Effective Date:
Lifetime Maximum: Payable at: %

If you are an adult, do you have adult ortho Insurance? Yes No
Do you need a referral from your primary dentist? Yes No
Do you have a second insurance? Yes No
Do you have another family member in treatment with us? Yes No
Is there a waiting period for ortho? Yes No
Have you used any of your ortho benefits? Yes No

For Office Use Only

Consult Ded Pre-existing
Banding Pay's M Q Auto Used
Extractions included in ortho max Age Limits



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ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

Patient Name

CONSENT FOR USE AND DISCLOSURE
OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Name: _____ Social Security # _____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will Consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
Communication barriers prohibited obtaining the acknowledgement
An emergency situation prevented us from obtaining acknowledgement
Other (Please Specify)



Your Name: _____

Thank you for visiting our office. Please take a minute and let us know how you found out about us by checking a box below. Thanks!

- Doctor Referral
 - Doctor's name: _____
- Yellow Pages
 - Yellowbook, Yellow Pages, or Area-Wide
- One of our patients referred you
 - Patient's name: _____
- Search Engine (Google, Yahoo, Bing, etc)
 - Name of search engine: _____
- Our Website www.StewartOrtho.com
- Facebook
- Family member is or was in treatment with us
 - Name: _____
- Insurance
 - Insurance provider _____
- Other
 - Please Specify _____