Bunn ORTHODONTIC GROUP

OT #: _____

Patient Registration Form and Medical/Dental History

The following information is required to accurately diagnose and correctly treat your bite and teeth problems. All information is strictly confidential and, although some questions may seem unimportant at the moment, they may be vital in case of emergency. Our staff will be happy to assist you with any questions you may have.

REFERRED BY: _____ TODAY'S DATE: _____

PATIENT INFORMATION:

Patient's Name: _____
Nickname: _____ SSN: _____
Birth Date: _____ Age: _____ Male: ____ Female: ____
Home Address: _____ City: _____ Zip: _____
Home Phone: (____) _____ Patient lives with: _____
E-Mail Address: _____
Interests/Hobbies: _____

FAMILY INFORMATION:

Mother's Name: _____ Occupation: _____
Home Phone: _____ Work Phone: _____ Mobile Phone: _____
Address (if different from above): _____
Father's Name: _____ Occupation: _____
Home Phone: _____ Work Phone: _____ Mobile Phone: _____
E-Mail Address: _____
Address (if different from above): _____
Other Children in Family (Name & Age): _____

PERSON RESPONSIBLE FOR ACCOUNT:

Name: _____ Relationship to Patient: _____
Home Address: _____
Previous Address _____
Employer: _____ Phone: _____
SSN: _____ Driver License #: _____
Home Phone: _____ Work Phone: _____ Mobile Phone: _____
E-Mail Address: _____
Emergency Contact: Name: _____ Relationship to Patient: _____
Home Phone: _____ Work Phone: _____ Mobile Phone: _____

MEDICAL HISTORY:

Physician's Name: _____ Last Visit: _____ Phone #: _____
Address: _____
Current medical health: Excellent: ____ Good: ____ Fair: ____ Poor: ____
Is patient currently under the care of a physician? If yes, please explain: _____
_____
Is patient taking any medications? Y/N If so, list: _____
Does patient have any allergies? Y/N What? (Aspirin, Metals, Plastics, Antibiotics, Latex) _____

Has patient ever had any of the following diseases or medical problems?

Y☐ N☐ Abnormal Bleeding	Y☐ N☐ Arthritis	Y☐ N☐ Heart Disease
Y☐ N☐ Diabetes	Y☐ N☐ Epilepsy/Seizures	Y☐ N☐ Severe/FrequentHeadaches
Y☐ N☐ High/Low Blood Pressure	Y☐ N☐ Kidney Problems	Y☐ N☐ Cancer/Chemotherapy
Y☐ N☐ Anemia	Y☐ N☐ Asthma	Y☐ N☐ Heart Murmur
Y☐ N☐ Difficulty Breathing	Y☐ N☐ Fever Blisters/Herpes	Y☐ N☐ Sinus Problems
Y☐ N☐ HIV+/AIDS	Y☐ N☐ Emotional Problems	Y☐ N☐ Congenital Heart Defect
Y☐ N☐ Artificial Joints/Valves	Y☐ N☐ Birth Defects	Y☐ N☐ Hepatitis
Y☐ N☐ Drug/Alcohol Abuse	Y☐ N☐ Glaucoma	Y☐ N☐ Tuberculosis
Y☐ N☐ Hospitalization/Surgery	Y☐ N☐ Rheumatic/Scarlet Fever	Y☐ N☐ Blood Transfusions

Please list any serious past or current medical problems: _____
Has patient ever taken Fosamax, Actonel, Bonivia, or any other bisphosphonate? _____
Does patient smoke or use tobacco in any other form? _____
Has patient ever taken PhenPhen? _____
Is patient taking any growth hormones? _____
Female patients: Has patient reached menstruation/puberty? Y☐/N☐
Are you pregnant? Y☐/N☐ If yes, how many weeks? _____

DENTAL HISTORY:
Dentist's Name: _____ Last Visit: _____ Phone#: _____
Address: _____
Current dental health: Excellent☐ Good☐ Fair☐ Poor☐
Has patient ever had a serious/difficult problem associated with any previous dental work? Y☐/N☐
Has patient ever been evaluated for orthodontic treatment? Y☐/N☐

Habits:

Y☐/N☐ Clenching/Grinding Teeth	Y☐/N☐ Thumb/Finger Sucking	Y☐/N☐ Tongue Thrust
Y☐/N☐ Mouth Breather	Y☐/N☐ Nail Biting	Y☐/N☐ Speech Problems

Has patient ever experienced:
Y☐/N☐ Pain/discomfort in the jaw joint? Explain: _____
Y☐/N☐ Locked jaw? Open lock _____ Closed lock _____ Associated with pain? Y☐/N☐
Y☐/N☐ Clicking or popping? Right ____ Left ____ Upon opening ____ Assoc. w/ pain? Y☐/N☐
Y☐/N☐ Frequent/Severe Headaches? Upon waking ____ During the day ____ Location of pain _____

Has patient ever had an injury to the: Face ____ Mouth ____ Teeth ____ Chin _____
Why are you currently seeking treatment? _____
What would you like orthodontic treatment to accomplish? _____

I certify to the best of my knowledge that all answers pertaining to _____ are true and correct .
(Name of Patient)
I hereby give permission to Bunn Orthodontic Group and the clinical team to take any radiographs, photographs and/or study models deemed necessary to allow complete diagnosis and treatment planning.

_____ _____ _____ _____
Patient / Parent or Guardian Signature Relationship Date

If this office accepts insurance, I understand that I am responsible for the payment of services rendered for any portion my insurance does not pay.

_____
Signature Date

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

FOR OFFICE USE ONLY

INITIAL VISIT: DATE: ________________

Dr. Comments: ____

____

B.P.: __________ Pulse: _______________ Last Dental Exam: _________________

Signed: ___________________________________ Date Signed: ___________________
(Parent or Guardian)

Signed: ___________________________________ Date Signed: ___________________
(Dr.'s Signature)

MEDICAL HISTORY UPDATE OR CHANGES

Date/Comments: ____

____

B.P. __________ Pulse: _______________ Last Dental Exam: _________________

Signed: ___________________________________ Date Signed: ___________________
(Parent or Guardian)

Signed: ___________________________________ Date Signed: ___________________
(Dr.'s Signature)

MEDICAL HISTORY UPDATE OR CHANGES

Date/Comments: ____

____

B.P. __________ Pulse: _______________ Last Dental Exam: _________________

Signed: ___________________________________ Date Signed: ___________________
(Parent or Guardian)

Signed: ___________________________________ Date Signed: ___________________
(Dr.'s Signature)

MEDICAL HISTORY UPDATE OR CHANGES

Date/Comments: ____

____

B.P. __________ Pulse: _______________ Last Dental Exam: _________________

Signed: ___________________________________ Date Signed: ___________________
(Parent or Guardian)

Signed: _____ Date Signed: _____
(Dr.'s Signature)

Update Patient Information

Patient's Name: _____
Home Address: _____
Home Phone: _____ Cell Phone: _____
Date: _____ E-Mail Address: _____

Patient's Name: _____
Home Address: _____
Home Phone: _____ Cell Phone: _____
Date: _____ E-Mail Address: _____

Patient's Name: _____
Home Address: _____
Home Phone: _____ Cell Phone: _____
Date: _____ E-Mail Address: _____

Patient's Name: _____
Home Address: _____
Home Phone: _____ Cell Phone: _____
Date: _____ E-Mail Address: _____

Patient's Name: _____
Home Address: _____
Home Phone: _____ Cell Phone: _____
Date: _____ E-Mail Address: _____

Bunn
ORTHODONTIC GROUP

NOTICE OF PRIVACY PRACTICES
AND
APPLICATION FOR SERVICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATON. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Federal and state law requires us to maintain the privacy of your health information. That law also requires us to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices we describe in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and health care operations. For example:
Treatment: We may use your health information for treatment or disclose it to a dentist, physician or health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to use or disclose. If you are not present, or in the event of your incapacity or n emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;
- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to an organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

BUNN ORTHODONTIC GROUP

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited expectations. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may request access by sending us a letter to the address at the end of this notice. If you request copies we will charge you a reasonable cost-based fee that may include copying costs, and postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we may--but are not required to—prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for more information about fees.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we may charge you responsible, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for more information about fees.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must take your request in writing. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you believe that:

- we may have violated your privacy rights,
- we made a decision about access to your health information incorrectly,
- our response to a request you made to amend or restrict the use or the disclosure of your health information was incorrect, or
- we should communicate with you by alternative means or at alternative locations,

You may contact us using the information listed below. You also may submit a written complaint to the 1) Office of the Attorney General, 2) Texas State Board of Dental Examiners, and/or 3) Bunn Orthodontic Group. We will provide you with the address to file your complaint with the 1) Office of the Attorney General, 2) Texas State Board of Dental Examiners, and/or 3) Bunn Orthodontic Group upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the 1) Office of the Attorney General, 2) Texas State Board of Dental Examiners, and/or 3) Bunn Orthodontic Group.

Office of the Attorney General
P.O. Box 12307
Austin, TX 78711-2307
1-800-252-8011

Bunn Orthodontic Group
7230 Briar Pl
San Antonio, TX 78221
210-912-9191

Texas State Board of Dental Examiners
333 Guadalupe, Tower 3, Suite 800
Austin, TX 78701-3942
512-463-6400

Bunn ORTHODONTIC GROUP

OT #: _____

Office Policy

Thank you for choosing **Bunn Orthodontic Group** for your orthodontic care. We are here to make your visit a pleasant experience. Our office is designed to put you and the patient at ease and our staff is devoted to assist you with any questions you may have.

Office Policy:

- When you arrive at the office, be sure to check-in using our check-in screen or let the receptionist know you have arrived immediately.
- NO food or drinks are allowed in our office.
- Please do not leave small children (infants, toddlers, children in strollers) unattended.
- Parents/Guardians must stay in the building at all times while the patient is being treated, in case we need to discuss the patient's treatment progress. (If patient is left unattended, we will not be able to treat them.)
- We try to see all our patients on time. Because of this policy we have a strict rule on late patients. Therefore, if you are more than **15** minutes late for your appointment you will be asked to re-schedule your appointment.
- In order to keep our schedule updated and be respectful to all other patients, we require 24 to 48 hours advance notice to cancel or change an appointment. Failure to give sufficient notice will result in a no show fee.
- Please brush your teeth before we begin working on your teeth when you arrive at the chair for your treatment. We have disposable toothbrushes and paste available for you.
- If you choose our Office Payment Plan, we require a credit card on file. We will keep your card on file and only charge your card if your monthly payment is not received or you have authorized automatic monthly payments to your card.

_____
INITIALS

If you have any questions, please feel free to ask the receptionist, and she will gladly escort you to the clinic area to speak with the doctor and/or assistant to discuss all questions you may have.

I have read and understood the office policy for **Bunn Orthodontic Group**.

Patient's Name: _____

Parent's Signature: _____ Date: _____

Bunn
ORTHODONTIC GROUP

OT #: _____

Acknowledgement Letter

Patient: _____ Date: _____

_____ (Initials) Missing Appointments

I understand it is very important that the patient comes to all scheduled appointments. If more than (3)three appoinments are missed a decision will be made whether to continue or terminate treament, if a decision is made to continue treatment a fee will be applied for any further missed appointments.

_____ (Initials) Oral Hygiene:

I understand it is very important that the patient brushes and flosses properly after every meal or snack. Food, plaque, and bacteria could lead to tooth decay, infections, and even bone loss.

_____ (Initials) Oral Appliances:

I understand RPE's, TPA's, Palatal/Lingual Bars, and Retainers must be properly taken care of. These appliances are an important part of the treatment, to create space or maintain space. Appliances must be worn as instructed by the doctor and or assistant and must be kept clean. If the appliance is lost, removed, or broken, the patient is responsible for the cost to replace the appliance. This may affect the orthodontic treatment.

_____ (Initials) Appliance Breakage

I understand it is very important to maintain the orthodontic appliances. If the appliance is broken or lost, it will compromise the quality and time of the orthodontic treament. It is very important that the patient take good care of their appliance so the treament can be completed.

_____ (Initials) Elastic Wear (rubber bands):

I understand elastics must be worn as instructed by the doctor. The reason patients wear aleastics is to settle the occlusion (bite), and fit and relate the upper jaw with the lower jaw. If the elastics are not worn properly, it will delay and/or not allow your treament to be completed.

_____ (Initials) Surgical Procedures:

I understand some of the surgical procedures necessary for orthodontice treatment include extraction of teeth, surgical exposure of impacted teeth, and possible orthognatic surgery. These procedures are not performed in our office; we will assist you in getting an appointment with the appropriate doctor.

If you have any questions or suggestions, please let the receptionist know, and they will escort you to the attending Doctor in our office.

_____
Parent/Guardian Signature

_____
Witness

_____
Patient's Signature

03E

7230 Briar Place, San Antonio, Texas 78221 Phone: (210) 921-9191 Fax (210) 921-2408

Bunn ORTHODONTIC GROUP

OT #: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You may refuse to sign this acknowledgement**

By signing this form, you acknowledge receipt of the "Notice of Privacy Practices" of Bunn Orthodontic Group. Our "Notice of Privacy Practices" provides information about how we may use and disclose your protected health information. We encourage you to read it in full. Our "Notice of Privacy Practices" is subject to change.

If you have any questions about our "Notice of Privacy Practices," please contact our office.

I acknowledge receipt of the "Notice of Privacy Practices" of Bunn Orthodontic Group.

Patient's Name: _____

Print Name: _____

Responsible Party

Signature: _____

Responsible Party

Date: _____ Time: _____ am/pm

FOR OFFICE USE ONLY

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

☐ Individual refused to sign

☐ Other (Please specify):

_____

Witness: _____ Date: _____

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Bunn
ORTHODONTIC GROUP

POTENTIAL RISK AND LIMITATION 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. While recognizing the benefits fo a pleasing smile and healthy teeth, you should also be aware that orthodontic treatment, like any treatment of the body, has some inherent risks and limitations. These risks and limitations usually do not contraindicate treatment but should be considered in making the decision to wear orthodontic appliances. Some of these possible problems are explained in the following paragraphs. Please fee free to ask any questions about these at the pretreatment consultation.

Decalcification (permanent markings), decay, or gum disease can occur if patients do not brush their teeth properly and thoroughly during the treatment period. Excellent oral hygiene and plaque removal is a must. Sugars and between meal snacks should be minimized.

Teeth have a tendency to rebound toward their original position after orthodontic treatment. This is called relapse. Very severe problems have a higher tendency to replace and the most common area for relapse is the lower front teeth. After appliance removal, a positioner or retainers are placed to minimize this change. Full cooperation in wearing these appliances is vital. We will make our correction to the highest standards and in many cases over correct, in order to accommodate the rebound tendencies.When retention is discontinued some relapse is still possible.

A non-vital or dead tooth is a possibility. A tooth that has been traumatized from a deep filling or even a minor blow can die over a long period of time with or without orthodontic movement. Such an affected tooth may require endodontic (root canal) treatment to maintain it.

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. It should be noted that not all root resorption arise from orthodontic treatment. Trauma, impaction, endocrine disordersm or idiopathic reasons can also cause root resorption.

There is also risk that problems may occur in the temporomandibular joints (lower jaw joints). Although this is rare it is a possibility. Tooth alignment or bite correction can improve tooth -related causes of joint pain but not in all cases. Tension appears to play a role in the frequency and severity of joint pains.

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

7230 Briar Place, San Antonio, Texas 78221 Phone: (210) 921-9191 Fax (210) 921-2408

The total time for treatment can be delayed beyond our estimate. Lack of facial growth, poor elastic wear or headgear cooperation, broken appliances and missed appointments are all important factors which could lengthen treatment time and effect the quality of the result.

Headgear instructions must be followed carefully. A headgear that is pulled outward while the elastic force is attached can snap back and poke into the face or eyes. Be sure to release the elastic force before removing the headgear from the teeth.

So, please, let's make every effort to do it right. This takes cooperation from everyone – Bunn Orthodontic Group, the staff, your family and, most of all, the patient.

We thank you in advance for your cooperation in this matter.

INFORMED CONSTENT

As the person responsible for _____, I consent to the orthodontic treatment recommended by Bunn Orthodontic Group. It has been explained to me by the Doctor and I understand that during orthodontic treatment and retention occassionally certain conditions can occur. These can include: Pain (discomfort), tooth mobility, tooth decay, tooth decalcification, devitalization (nerve loss), tooth and/or jaw changes, spaces between teeth, facial changes, swalloning of appliances, speech changes, and injury resulting from removable appliances.

Treatment alternatives have been explained including no treatment; as well as the preferred method of treatment with which I have concurred. I understand that for a successful orthodontic result and to lessen the dangers of complication, the following conditions are essential:

1. Excellent oral hygiene.
2. Proper diet controls (no hard sticky or chewy foods, sweet or otherwise).
3. Strict adherence to instructions in the wearing of appliances.
4. Cooperation in keeping appointments

I understand that there is no specific warranty or guarantee as to any result and/or cure. I also understand that I can, at any time, ask for and receive a full recital of all possible risks attendand to phases of this orthodontic treatment.

_____	_____	_____
Parent/Responsible Party	Date	Witness

7230 Briar Place, San Antonio, Texas 78221 Phone: (210) 921-9191 Fax (210) 921-2408

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DENTAL DISCLAIMER

Bunn Orthodontic Group is a group of specialty Doctors in orthodontics. The x-rays taken in this office are to diagnose for orthodontic treatment. These x-rays are not used specifically for diagnosis of cavities. When patients begin orthodontic treatment, we assume that they have had an exam and cleaning and have completed any dental work needed. Patients will be expected to see their general dentist every six months for an exam and cleaning during orthodontic treatment.

I hereby release Bunn Orthodontic Group from any liability if cavities detected during treatment.

_____	_____	_____
Parent/Responsible Party	Date	Witness

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