



Welcome to our office. In order for us to provide the best orthodontic care for your child we will need your cooperation. We are here to answer your questions and comments at any time. You can call us in **Toms River** at (848) 240-2429, **Bedminster** at (908) 781-2037, or email us at bedminsterortho@gmail.com

OFFICE POLICY

1. All appointments must be kept. Orthodontic treatment can only be completed properly if you keep your appointments. If you miss three appointments without proper notification, treatment can be terminated. We have the right to terminate treatment for lack of cooperation.
2. Cancellations must be called in 24 hours prior to your appointment. We understand that emergencies come up, but please notify our office if you cannot keep your appointment.
3. You must call for any loose or broken appliances prior to your child's scheduled appointment. If you come in on the day of your appointment with something broken we may need to reschedule your appointment if time does not allow for us to fix it. Excessive breakage (more than three times) is not acceptable and can result in the termination of treatment.
4. Oral hygiene is very important. Your child is expected to brush their teeth at least three times a day. If your child's oral hygiene becomes a problem and affects their treatment, we have the right to cease treatment until there is an improvement. If there is no improvement, your child's treatment can be terminated.
5. You must see your dentist every 6 months for cleaning and an exam.
6. Please make your next appointment at the time of your appointment. Appointments are given based on availability and fill up quickly.
7. If your insurance benefit is ineligible or terminated for any reason, you will be responsible for the balance.

Signature _____ Date _____



Orthodontic Treatment Consent for Meryl A. Baumash, D.D.S

While a pleasing smile, more balanced face, and healthier bite are widely appreciated, orthodontic treatment is an elective procedure. Like any other treatment of the body, it has inherent risks and limitations. Please read the following information carefully and ask us any questions you have so that you fully understand these risks. Also understand that we feel the benefits of orthodontic treatment far outweigh the risks.

Cooperation: Patient cooperation is the most important factor in completing treatment on time. Insufficient wearing of elastics, removable appliances, or headgear; broken appliances, missed appointments, and poor oral hygiene prevent the desirable results we all anticipate. Lack of cooperation is the most common cause of excessive treatment time, increased fees, and disappointing results. Soreness and irritation may occur after braces are placed or adjusted.

Decalcification and Cavities: Good oral hygiene is a must during orthodontic treatment. Tooth discoloration and decay can occur if patients eat food containing excessive sugar and/or if they do not brush their teeth properly. Inadequate cleaning can also cause gum disease, and loose brackets and bands. Although gum problems can occur when not wearing braces, the risk is greater during orthodontic treatment.

Periodontal Problems: Proper brushing and flossing can usually prevent swollen, inflamed and bleeding gums. Periodontal disease is most often caused by the accumulation of plaque and debris around the teeth and gums. However, unknown causes can also lead to progressive loss of supporting bone and gums. This most frequently occurs in patients with a tendency toward gum disease with or without braces. If periodontal problems become uncontrollable, orthodontic treatment may have to be discontinued prior to completion.

Root Resorption: Some patients are prone to tooth roots shortening during orthodontic treatment. Under healthy conditions, shortened roots are no problem. However, combined with significant gum or supporting bone problems, the longevity of the involved teeth may be threatened.

TMJ Problems: Patients with bad bites have a high potential for TMJ (jaw joint) problems, which may become evident during or after orthodontic treatment. TMJ problems may include jaw pain, ear pain, headaches, neckaches, etc. Orthodontic treatment may help remove the dental causes of TMJ problems, but has no effect on non-dental causes. An equilibration of the biting surfaces of the teeth, long-term use of an occlusal splint, or TMJ surgery may be necessary after orthodontic treatment. Remember, the majority of people with TMJ problems have never had orthodontic treatment.

Root Canals: A tooth previously injured by trauma or a large filling can die over a period of time with or without orthodontic treatment, and may result in the tooth darkening. This condition, seldom due to orthodontics alone, may require root canal treatment.

Relapse: Shifting or settling of teeth following treatment and retention often occurs in varying degrees. Some undesirable changes may include rotations, crowding of the lower front teeth, spaces at extraction sites, and spaces between upper front teeth. The eruption of wisdom teeth, previously rotated teeth, mouth breathing, and uncontrolled muscle habits are the most frequent causes. The best way to minimize undesirable changes is to wear retainers every night or a few evenings each week for an indefinite period. Teeth will move if retainers are not worn.

Digit Habits: Continued finger or thumb sucking and incorrect swallowing may extend treatment time. Uncontrolled muscle habits may also cause undesirable tooth shifting following treatment. If significant, retreatment involving an additional fee may be necessary.

Undesirable Jaw Growth: Occasionally, insufficient or excessive jaw growth can limit the desired results. On rare occasions, we may need to recommend a treatment plan change to include extractions or jaw surgery. If substantial undesirable growth changes occur after active treatment, retreatment at an additional fee may be needed.

Impacted Teeth: Various problems may be encountered during attempts to move an impacted tooth, and may lead to periodontal problems or the loss of the tooth. Occasionally, the tooth becomes trapped under another tooth and the extraction of one of the teeth becomes necessary. Rarely, the impacted tooth fails to move even when there is room and it must be extracted, which may require a bridge or implant replacement.

Oral Surgery: Sometimes, tooth removal, Temporary Anchorage Devices (TADs), or oral surgery is necessary in conjunction with orthodontic treatment, especially to correct severe jaw imbalances. Oral surgery presents risks and potential disabilities. Discuss these risks with your oral surgeon and family dentist **before deciding to proceed with surgery.**

Headgear: If a headgear is pulled out with the elastic force still attached, the metal part may snap back and injure the face, eye, etc. Safety devices have been developed to prevent this, but injury may still be caused by careless or improper use.

Ceramic Bracket: Ceramic brackets may cause excessive wearing of tooth enamel. Also, ceramic brackets are more brittle than steel and may break. These fractured brackets may be swallowed or inhaled, and since they do not appear on x-rays, are difficult for a physician to locate.

Allergies: Allergies to orthodontic materials may occur during orthodontic treatment. Known allergies can be avoided, but if they are unknown to you, it is impossible to predict any reaction. People who have other allergies are more prone to have allergies to orthodontic materials.

Unusual Occurrences: Unusual occurrences such as swallowing an appliance, bracket, band, or the end of an archwire; dislodging a restoration, enamel reduction may be necessary.

Treatment Time: The time required to complete treatment may exceed the original time estimate. Most often, treatment is delayed due to poor cooperation, poor oral hygiene, missed appointments, or unusual growth patterns. Occasionally it is in the best interest of the patient to discontinue treatment and place retainers even though treatment has not achieved the desired results.

Necessary Dental Work: All necessary dentistry must be completed prior to starting orthodontic treatment. Also, the patient must maintain regular dental checkups every six months during treatment. Adults must visit their dentist for scaling and cleaning every three to six months during treatment, according to their needs.

It is our intent to inform you of the potential problems that exist during orthodontic treatment. Most of these conditions occur rarely, and other even more rare risks may also exist. You should be aware that these things can happen. If any of these conditions should develop, every effort will be made to refer the patient to the appropriate therapist. Quality treatment depends on a close professional working relationship: Patients should feel free to inquire about any aspect of treatment. Understanding and cooperation are essential for the result we both seek.

I consent to the taking of photographs and x-rays before, during and after treatment, and to the use of the same by the Doctor in scientific paper demonstrations.

I have read and understand the above, and all questions have been answered to my satisfaction. I authorize the necessary orthodontic treatment.

Patient Name: _____

Responsible Party Signature

Date



HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient’s rights section describing your rights under the law.

You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations.

We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that: Protected health information may be disclosed or used for treatment, payment, or healthcare operations.

The practice reserves the right to change the privacy policy as allowed by law. The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions. The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO
May we leave a message on your answering machine at home or on your cell phone? YES NO
May we discuss your medical condition with any member of your family? YES NO If YES, please name the members allowed: _____

This consent was signed by: _____ (PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

1. PATIENT INFORMATION

Patient's Full Legal Name (Last, First, Middle)

Date of Birth

Age

Preferred Name / Nickname

Gender

Male

Female

Non-binary

Prefer not to say

Address (Street)

City

State

ZIP

Home Phone

Cell Phone

Email Address

School / Employer

Grade / Occupation

Social Security # (optional)

2. RESPONSIBLE PARTY / GUARANTOR

Responsible Party Name (if different from patient)

Relationship to Patient

Address (if different from patient)

City

State

ZIP

Home Phone

Cell Phone

Work Phone

Ext.

Email Address

Best Way to Contact

Phone

Text

Email

Employer / Employer Address

Date of Birth

Marital Status:

Single

Married

Divorced

Widowed

Separated

3. DENTAL INSURANCE INFORMATION

I do not have orthodontic insurance — skip to Section 4

Primary Insurance Company Name

Group Number

Policy / Member ID

Insurance Holder's Full Name

Relationship to Patient

Date of Birth

Insurance Company Phone

Insurance Company Address

Secondary Insurance:

Yes

No

Secondary Insurance Company Name

Group Number

Policy / Member ID

Secondary Holder's Full Name

Relationship to Patient

Date of Birth

4. MEDICAL HISTORY

Primary Care Physician Name

Physician Phone

Last Physical Exam

Current Medications (list all, including vitamins/supplements)

Known Allergies

Please check all conditions that apply to the patient:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Arthritis / Joint Problems | <input type="checkbox"/> Asthma / Breathing Problems | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Blood Pressure Issues |
| <input type="checkbox"/> Cancer / Chemotherapy | <input type="checkbox"/> Cleft Lip / Palate | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy / Seizures |
| <input type="checkbox"/> Growth Hormone Therapy | <input type="checkbox"/> Head / Neck Injuries | <input type="checkbox"/> Heart Condition / Murmur | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Mental Health Condition | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Snoring / Sleep Apnea | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Tonsil / Adenoid Issues | <input type="checkbox"/> Other (describe below) | | |

If other or additional medical notes, please describe:

Previous surgeries / hospitalizations (type and date):

5. DENTAL HISTORY

Name of Current General/Pediatric Dentist

Date of Last Dental Visit

X-rays Taken?

- Yes No

Had orthodontic treatment before? Yes No

Had oral surgery? Yes No

If yes to either above, please describe:

Please check any dental concerns:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Crowding | <input type="checkbox"/> Spacing / Gaps | <input type="checkbox"/> Overbite | <input type="checkbox"/> Underbite |
| <input type="checkbox"/> Crossbite | <input type="checkbox"/> Open Bite | <input type="checkbox"/> Thumb / Finger Sucking | <input type="checkbox"/> Mouth Breathing |
| <input type="checkbox"/> Jaw Pain / Clicking (TMJ) | <input type="checkbox"/> Difficulty Chewing | <input type="checkbox"/> Speech Problems | <input type="checkbox"/> Teeth Grinding / Clenching |
| <input type="checkbox"/> Missing Teeth | <input type="checkbox"/> Extra Teeth | <input type="checkbox"/> Gum Problems | <input type="checkbox"/> Other |

Primary reason for seeking orthodontic treatment:

6. AIRWAY & SLEEP HEALTH

Airway and sleep health are closely connected to jaw development and orthodontic outcomes. Please answer the following questions as accurately as possible.

Please check all breathing / airway symptoms that apply:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Mouth Breathing (day) | <input type="checkbox"/> Mouth Breathing (night) | <input type="checkbox"/> Nasal Congestion / Blockage |
| <input type="checkbox"/> Frequent Ear / Sinus Infections | <input type="checkbox"/> Enlarged Tonsils / Adenoids | <input type="checkbox"/> Deviated Septum (diagnosed) | <input type="checkbox"/> Allergies affecting breathing |
| <input type="checkbox"/> Difficulty breathing through nose | <input type="checkbox"/> Choking / Gaspings during sleep | <input type="checkbox"/> Observed pauses in breathing | <input type="checkbox"/> Noisy / Labored breathing |

Please check all sleep-related symptoms that apply:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Restless / Fitful sleep | <input type="checkbox"/> Frequent nighttime waking | <input type="checkbox"/> Teeth Grinding / Clenching (sleep) |
|--|--|--|---|

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Bedwetting (children) | <input type="checkbox"/> Nightmares / Night Terrors | <input type="checkbox"/> Sleepwalking / Talking | <input type="checkbox"/> Heavy sweating during sleep |
| <input type="checkbox"/> Wakes unrefreshed / tired | <input type="checkbox"/> Daytime sleepiness / fatigue | <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Hyperactivity / ADHD symptoms |
| <input type="checkbox"/> Headaches upon waking | <input type="checkbox"/> Dry mouth upon waking | <input type="checkbox"/> Dark circles under eyes | <input type="checkbox"/> Delayed growth / development |

Diagnosed with a sleep disorder? Yes No

If yes, diagnosis: _____ Date of any sleep study: _____

Currently using CPAP / BiPAP / oral appliance? Yes No

If yes, device type: _____ Provider / Specialist name: _____

Seen an ENT, sleep specialist, or pulmonologist? Yes No

Overall sleep quality: Excellent Good Fair Poor Very Poor

Average hours of sleep per night: < 5 hrs 5–6 hrs 6–7 hrs 7–8 hrs 8–9 hrs 9+ hrs

Additional comments about airway, breathing, or sleep concerns:

7. EMERGENCY CONTACT

Emergency Contact Name	Relationship to Patient	Phone Number
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8. FINANCIAL POLICY & CONSENT

I understand that orthodontic treatment requires a financial commitment. I agree to the payment arrangements established with this office. I authorize the release of any dental or medical information necessary to process insurance claims. I understand that I am ultimately responsible for all charges incurred regardless of insurance coverage. I authorize this practice to take radiographs, photographs, and other diagnostic records necessary for treatment. I certify that the information provided on this form is complete and accurate to the best of my knowledge.

Signature of Patient or Guardian

Printed Name

Date

For Office Use Only — Date Received: _____ Staff Initials: _____ Chart #: _____