MITCHELL ORTHODONTICS

3973 Atlanta Highway, Ste 600 * Loganville, GA 30052 * 770-466-8040

So that we can best meet your needs, please complete this questionnaire in full.

PATIENT'S NAME First_____M._____Last_____GOES BY_____

SEX_____ DATE OF BIRTH ___/___/___ AGE_____ SCHOOL_____GRADE_____

MAILING ADDRESS_____City _____ST_____Zip_____

HOME PH #_____CELL #_____ REFERRED BY_____

PATIENT'S DENTIST_____ LAST DENTAL CLEANING: _____/_____/_____

PREVIOUS ORTHO TREATMENT OR EXAM: Date _____ BY WHOM_____

PATIENT REACTION TO ORTHO TREATMENT: ___EAGER ___COMPLACENT ___ANTAGONISTIC ___NERVOUS

DOCTOR/PHYSICIAN _____

FATHER'S NAME: First_____M._____Last_____

Date of Birth _____ SS #_____-_____-_____ EMAIL_____

MAILING ADDRESS_____ CITY_____ ST _____ ZIP _____
(If different from patient)

HOME PH #_____ CELL #_____

HOME OWN OR RENT? _____ HOW LONG AT CURRENT ADDRESS? _____

EMPLOYER_____ WORK PH #_____

HOW LONG AT CURRENT EMPLOYER? _____ SOURCE OF INCOME □ Employed, □ Retired, □ None, □ Other

MOTHER'S NAME: First_____M._____Last_____ SS #_____-_____-_____

Date of Birth _____ SS #_____-_____-_____ EMAIL_____

MAILING ADDRESS_____CITY _____ST_____ ZIP _____

HOME PH #_____ CELL #_____

HOME: OWN OR RENT? _____ HOW LONG AT CURRENT ADDRESS? _____

EMPLOYER_____ WORK PH #_____

HOW LONG AT CURRENT EMPLOYER? _____SOURCE OF INCOME □ Employed, □ Retired, □ None, □ Other

EMERGENCY CONTACT _____RELATIONSHIP_____ PH #_____
(OTHER THAN PARENT/GUARDIAN)

HAS THIS OFFICE RENDERED TREATMENT TO ANY FAMILY MEMBERS? Yes ____ No ____ IF SO, WHAT IS THE

NAME OF THE FAMILY MEMBER_____ RELATIONSHIP_____

DENTAL INSURANCE INFORMATION ***(PLEASE BE THOROUGH WITH ALL QUESTIONS)***

POLICY HOLDER NAME: _____ DATE OF BIRTH ___/___/___ SS #_____-____-_____

EMPLOYER_____ PH # _____

INSURANCE NAME: _____ ID #: _____

GROUP #: _____ INSURANCE PH # _____

By signing this I authorize the release of any information to process dental claims. I understand I am responsible for all costs of treatment. I understand that the information I have provided is correct to the best of my knowledge. I also understand this information will be held in strict confidence and I understand that a credit bureau report may be obtained on the responsible party *(whoever signs the contract)*. If transfer patient, I authorize the transfer of my records to George T. Mitchell, DDS

Signature _____ Date _____

MEDICAL HISTORY

Your current health is: Excellent Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain_____

Are you taking any medications? Yes No

Please list medications_____

_____

Do you smoke or use any other form of tobacco? Yes No

For Women: Are you pregnant? Yes No
Are you nursing? Yes No

Have you ever had any of the following diseases or medical problems? ***Please circle all that apply***

Anemia	Glaucoma
Arthritis	HIV+ / AIDS
Asthma	Hepatitis
Blood transfusion	Herpes
Bone disorder	Hemophilia
Cancer	High / low blood pressure
Cerebral Palsy	Heart problems
Congenital heart defect	Kidney problems
Diabetes	Mitral Valve Prolapse
Drug/alcohol abuse	Mono
Ear problems	Removal of tonsils/adenoids
Endocrine problems	Rheumatic fever
Epilepsy	Sickle Cell Disease
Fever blisters	Sinus problems
Frequent headaches	Thyroid problems
	Tuberculosis

Please list any serious medical condition(s) and/or surgeries you have ever had:

_____

_____

Is patient adopted? Yes No

ALLERGIES

Y N	Aspirin	Y N	Latex
Y N	Penicillin	Y N	Tetracycline
Y N	Sulfa drugs	Y N	Codeine
Y N	Erythromycin	Y N	Jewelry / Metal

Please list any other drugs and/or material you are allergic to:

_____

DENTAL HISTORY

What is your chief dental complaint? *Please circle all that apply.*

Crowding	Improve Chewing	Overbite
Spacing	Crossbite	Shifting
Grinding	Thumb/finger habit	Overall appearance
Jaw Pain	Clicking	Jaw Locks

Other _____

Please circle all that apply:

Fluoride toothpaste used	*Thumb/finger habit*
Blow / injury to face or teeth	*Speech problems*
Permanent teeth removed	*Baby teeth removed*
Cleft lip/palate	*Breathing problems*
Problems swallowing	*Problems chewing*
Night time teeth grinding	*Clicking or pain in jaw*

Do you require antibiotics before dental treatment? Y N

Are you currently in pain? Y N

Have you ever had a serious problem associated with any previous dental work? Y N

Your current dental health is? *Good Fair Poor*

Do you like your smile? Y N

Do your gums bleed? Y N

How many times a day do you brush? _____

How many times a day do you floss? _____

Type of toothbrush? hard medium soft

Please list any major dental procedures you have had:

_____

Please list any major dental procedures you and your dentists have discussed or that you have scheduled:

_____

CONSENT

I understand that the information I have given today is correct to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical / dental 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 of Patient or Parent/Guardian Date

NOTICE OF PRIVACY PRACTICES
MITCHELL ORTHODONTICS
GEORGE T. MITCHELL, DDS

THIS NOTICE DESCRIBES HOW HEALTH 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 cleanings, 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 payment etc.):

- Internally, to all staff members who have any role in your treatment.

- To other patients and third parties who may 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 your treatment.

Any other uses or disclosures 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 with us (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 the 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.

_____

Signature – Responsible Party or Patient

_____

Print Name – Responsible Party or Patient

_____

Date

MITCHELL ORTHODONTICS
3973 Atlanta Hwy., Ste 600
Loganville, GA 30052

LETTER OF INFORMATION AND CONSENT AGREEMENT

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 of a pleasing smile and healthy, functional teeth, you should also be aware that orthodontic treatment, like any treatment of the body, has some hazards, inconveniences and limitations. These drawbacks seldom outweigh the long-range benefits, but should be considered in making the decision to wear orthodontic appliances.

Perfection is always our goal. Dr. Mitchell will use his knowledge, training, skills and experience to achieve perfect function that is also esthetically pleasing, but much depends on the patient's growth patterns, genetics, oral health and cooperation.

Throughout life, tooth positions are constantly changing. This is true with individuals regardless of whether they have worn braces or not. After orthodontic treatment; patients are subject to the same subtle changes that occur in non-orthodontic patients. In the late teens or early twenties orthodontic patients may notice slight irregularities developing in their front teeth. This is particularly true if the teeth were extremely crowded prior to treatment. Prolonged wearing of a retainer may be the only way to prevent this if it becomes undesirable.

Decalcification (permanent markings on the teeth), tooth decay or gum disease can occur if patients do not brush and floss their teeth properly and thoroughly. Excellent oral hygiene and daily plaque removal are musts. Sugars and between-meal snacks should be eliminated. Regular check ups with your general dentist are necessary to check for decay and to professionally clean the teeth. Occasionally periodontal (gum) problems present before orthodontic treatment may be worsened by the wearing of braces and require treatment by another dental specialist.

Cold sores, canker sores and irritation 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 a need for extraction of teeth, fillings, crowns, bridges, gum treatment or other dental procedures before, during or after orthodontic treatment. If necessary, this will be done by another dentist.

On rare occasions the nerve of a tooth may become abscessed. A tooth that has been irritated by a deep filling or even a minor blow may require treatment by another dentist.

In some instances the root ends of the teeth are shortened during treatment. This is called root resorption. Under healthy circumstances the shortened roots are no disadvantage. There is no way to foresee whether this will happen and nothing can be done to prevent this from occurring.

There have been some reported incidents of patients experiencing bracket breakage and/or damage to the teeth, including attrition, enamel flaking on debonding and enamel fracturing. Fractured brackets may result in remnants which might be harmful to the patient.

There is also a very small chance that pain may occur in the lower jaw joints. Tooth alignment or bite correction can usually improve tooth related causes of jaw 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 objectives may have to be compromised. Skeletal growth disharmony is a biological process beyond the orthodontist's control.

Orthodontic treatment can succeed only through the joint cooperation of all parties involved. Together, we can achieve the best possible result. In many instances, lack of cooperation in the requested use of elastics, appliances, retainers and appointments will make a successful completion of treatment impossible or lengthen the duration of treatment.

We appreciate your confidence in selecting our office. We want you to be fully informed. Please ask us any questions 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, dental journals, books, meetings and patient education.

I have read and understand this letter of information and with this knowledge consent to treatment.

Signature	Relationship to Patient	Date