

Patient Questionnaire

During your treatment we will have many opportunities to get to know you, not only as a patient, but also as a friend. The info that you give us here will help us build this relationship. Feel free to answer only the questions that you are comfortable answering. Naturally, this info will only be shared with the members of this office.

1. What name do you prefer we call you?



2. Names and ages of any brothers/ sisters.

3. Do you have any friends or relatives in our practice?

4. Where do you go to school and what grade are you in?



5. What are your favorite subjects?



6. What do you like to do in your spare time?



7. What kind of sports do you play?



8. Do you have any pets?



9. Tell us something special about yourself.



10. What do you think about wearing braces?



Patient Information

Date ____/____/____
Name _____ Date of Birth ____/____/____ Age _____ Sex _____
Address _____ City/State _____ Zip Code _____
Home Phone _____ School _____
Name of Brothers and Sisters _____
Hobbies & Interests _____ Sporting Activities _____
Names of friends & / or relatives who were former patients _____
If patient is a minor, give parent's name or guardian's name _____
Whom may we thank for referring you to our office? _____
Patient's Dentist _____ Patient's Physician _____

Responsible Party Information (for patients under the age of 18)

Father _____ Date of Birth ____/____/____
Mailing address _____ How Long? _____
Social security # _____ Email address _____
Home Phone _____ Work Phone _____ Cell Phone _____
Employer _____ Occupation _____ # Yrs Employed _____
Are Parents: Married Widowed Separated Divorced

Mother _____ Date of Birth ____/____/____
Mailing address _____ How Long? _____
Social security # _____ Email address _____
Home Phone _____ Work Phone _____ Cell Phone _____
Employer _____ Occupation _____ # Yrs Employed _____

Insurance Information

(It is the patient's responsibility to know their Orthodontic Insurance benefits)

Do you have Orthodontic Insurance? YES NO If yes, complete the following:
Insured's Name _____ Insured's ID # _____
Insurance Company _____ Group # _____ Local # _____
Insurance Company Address _____
Insurance Company Phone # _____ Insured's Employer _____
Do you have dual coverage? YES NO If yes, complete the following:
Insured's Name _____ Insured's ID # _____
Insurance Company _____ Group # _____ Local # _____
Insurance Company Address _____
Insurance Company Phone # _____ Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____
Complete Address _____ Phone # _____

I understand that, where appropriate, credit bureau reports may be obtained and will be kept confidential.

Signature _____ Date _____

Medical History

Please answer all questions (check YES or NO and fill in the blanks where required)

1. Have tonsils and/or adenoids been removed? If yes, at what age? _____ YES NO
2. Have you been under the care of a physician during the past 2 years? YES NO
Other than routine checks. Reason? _____
3. Are you taking medications now? If yes, list: _____ YES NO
4. The following disease are of interest to the Orthodontist. Please check only appropriate disease:

<input type="checkbox"/> Allergies, list	<input type="checkbox"/> HIV Positive (AIDS)	<input type="checkbox"/> Bone Disorders	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Sore Throat (frequent)	<input type="checkbox"/> Rickets	<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Ear Infections (frequent)
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Prolonged Bleeding
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Anemia	<input type="checkbox"/> Endocrine Problems
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Emotional Disorders	<input type="checkbox"/> Asthma	
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Paget's disease	<input type="checkbox"/> Fainting or Dizziness	
5. Do you have any special problems not listed above? YES NO
Explain: _____

Oral Habits

The following are some habits commonly found which may influence tooth positions. List information as pertains to you:

1. Thumb sucking until age _____ Finger Sucking until age _____
Nail Biting _____ Mouth Breathing _____
Grinding of Teeth _____ Other habits _____
2. Have you ever had any speech therapy? _____ YES NO
3. List any musical instruments played _____ How Long? _____

Dental History

1. Date of last dental exam ___/___/___ By whom? _____ Is work completed? YES NO
2. Has patient had any serious trouble associated with any previous dental treatment? YES NO
If yes, explain: _____
3. Did any teeth have to be removed by the dentists? YES NO
4. Do any of your teeth hurt? If yes: upper right upper left lower right lower left
5. Have you ever had treatment for a periodontal disease (gum disease)? YES NO
6. Have you ever fallen and bumped your chin, or recieved a blow to your jaws? YES NO
7. Have there been any injuries to the teeth? YES NO
8. Have you ever had any surgery in the head or neck area? YES NO
9. Have there been any injuries to the head or face? YES NO
10. Has orthodontic treatment been suggested in the past? YES NO
11. Has an orthodontists been consulted previously? YES NO
12. Has any other family member had any previous orthodontic treatment? YES NO
13. Does patient have any reservations about orthodontic treatment of wearing braces or headgear? YES NO
14. What are you or your dentist more concerned about? (purpose of visit): _____

PATIENT TEMPOROMANDIBULAR JOINT HISTORY

Mattingly & Howell Orthodontics, PSC

Chris Mattingly, DMD

Chris Howell, DMD

Child/Adult Orthodontics

Patient: _____

Date: _____

Please answer the following questions, as they are very important to completing your health history.

Do you suffer from any of the following symptoms?

COMMENTS

- 1. Headaches..... YES NO
- 2. Dizziness..... YES NO
- 3. Lightheadness..... YES NO
- 4. Neckaches..... YES NO
- 5. Are you easily fatigued or tired at the end of the day..... YES NO
- 6. Forgetfulness or difficulty in learning new material..... YES NO
- 7. Ringing, buzzing or other sounds in the ears..... YES NO
- 8. A feeling of fullness in the ears or sinuses..... YES NO
- 9. Numbness or tingling of the fingertips..... YES NO
- 10. Backaches (upper or lower)..... YES NO
- 11. Difficulty in opening or closing your mouth..... YES NO
- 12. Clench or grind your teeth..... YES NO
- 13. Tired jaw muscles..... YES NO
- 14. Soreness, tightness or pain in muscles around jaw & face..... YES NO
- 15. Does it hurt to chew..... YES NO
- 16. Clicking/popping or grating sounds in jaw muscles..... YES NO
- 17. Jaws "locked" closed..... YES NO
- 18. Jaws "locked" wide open..... YES NO
- 19. Pain in the eye or visual problems..... YES NO
- 20. Frequently encounter stressful situations at home/work..... YES NO

If you have any of the above symptoms:

- 1. Have you ever been treated for them..... YES NO
- 2. Has the treatment been successful..... YES NO
- 3. Are you currently taking any medication for these symptoms... YES NO
- 4. If yes, which medications are you currently taking: _____

(Please continue on reverse side)

List your most severe symptoms (aches, pains, frequency, etc.) and the location and duration of each:

	<u>SYMPTOMS</u>	<u>HOW OFTEN</u>	<u>HOW LONG</u>	<u>HOW SEVERE</u>
1.				
2.				
3.				
4.				
5.				

NARRATIVE: Please explain in your own words the history of the problem

Please name other people in the health field that you have seen for the complaint:

	<u>Yes</u>	<u>No</u>	<u>Name</u>	<u>Result</u>
Family Doctor	_____	_____	_____	_____
Neurologist	_____	_____	_____	_____
Ear Doctor	_____	_____	_____	_____
Eye Doctor	_____	_____	_____	_____
Dentist	_____	_____	_____	_____
Physical Therapist	_____	_____	_____	_____
Psychologist	_____	_____	_____	_____
Other	_____	_____	_____	_____

Patient's Signature: _____

Date: _____

MATTINGLY & HOWELL ORTHODONTICS, PSC

**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

For Office Use Only

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

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

MATTINGLY & HOWELL ORTHODONTICS, PSC

NOTICE OF PRIVACY PRACTICES

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.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required 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 that are described in this Notice while it is in effect. This Notice takes effect 4/1/03, 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 changes are permitted by applicable law. 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 healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, 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 use 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 must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also 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.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

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

PATIENTS RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. 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 obtain a form to request access by using the contract information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$1.00 for each page, and postage if you want the copies mailed to you. 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 will 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 a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

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).

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 make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled 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 the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services 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 U.S. Department of Health and Human Services.

Contact Officer: Stephanie Riggs

Telephone: (502) 349-6300

Fax: (502) 349-1769

E-Mail: stephanie@bardstown.com

Address: 208 North 2nd Street
Bardstown, KY 40004



Mattingly & Howell
Orthodontics, PSC
A reason to smile!

INFORMED CONSENT

for the Orthodontic Patient Risks and Limitations of Orthodontic Treatment

Successful orthodontic treatment is a partnership between the orthodontist and the patient. The doctor and staff are dedicated to achieving the best possible result for the patient. As a general rule, informed and cooperative patients can achieve positive orthodontic results. While recognizing the benefits of a beautiful healthy smile, you should also be aware that, as with all healing arts, orthodontic treatment has limitations and potential risks. These are seldom serious enough to indicate that you should not have treatment; however, all patients should seriously consider the option of no orthodontic treatment at all by accepting their present oral condition. Alternatives to orthodontic treatment vary with the individual's specific problem, and prosthetic solutions or limited orthodontic treatment may be considerations. You are encouraged to discuss alternatives with the doctor prior to beginning treatment.

Orthodontics and Dentofacial Orthopedics is the dental specialty that includes the diagnosis, prevention, interception and correction of malocclusion, as well as neuromuscular and skeletal abnormalities of the developing or mature orofacial structures.

An orthodontist is a dental specialist who has completed at least two additional years of graduate training in orthodontics at an accredited program after graduation from dental school.



American Association of Orthodontists

Mattingly & Howell Orthodontics, PSC
2317 Stony Brook Drive
Louisville, KY 40220
(502) 895-3473

208 N. Second Street
Bardstown, KY 40004
(502) 349-8300



Third Molars

As third molars (wisdom teeth) develop, your teeth may change alignment. Your dentist and/or orthodontist should monitor them in order to determine when and if the third molars need to be removed.

Allergies

Occasionally, patients can be allergic to some of the component materials of their orthodontic appliances. This may require a change in treatment plan or discontinuance of treatment prior to completion. Although very uncommon, medical management of dental material allergies may be necessary.

General Health Problems

General health problems such as bone, blood or endocrine disorders, and many prescription and non-prescription drugs (including bisphosphonates) can affect your orthodontic treatment. It is imperative that you inform your orthodontist of any changes in your general health status.

Use of Tobacco Products

Smoking or chewing tobacco has been shown to increase the risk of gum disease and interferes with healing after oral surgery. Tobacco users are also more prone to oral cancer, gum recession, and delayed tooth movement during orthodontic treatment. If you use tobacco, you must carefully consider the possibility of a compromised orthodontic result.

Temporary Anchorage Devices

Your treatment may include the use of a temporary anchorage device(s) (i.e. metal screw or plate attached to the bone.) There are specific risks associated with them.

It is possible that the screw(s) could become loose which would require its/their removal and possibly relocation or replacement with a larger screw. The screw and related material may be accidentally swallowed. If the device cannot be stabilized for an adequate length of time, an alternate treatment plan may be necessary.

It is possible that the tissue around the device could become inflamed or infected, or the soft tissue could grow over the device, which could also require its removal, surgical excision of the tissue and/or the use of antibiotics or antimicrobial rinses.

It is possible that the screws could break (i.e. upon insertion or removal.) If this occurs, the broken piece may be left in your mouth or may be surgically removed. This may require referral to another dental specialist.

When inserting the device(s), it is possible to damage the root of a tooth, a nerve, or to perforate the maxillary sinus. Usually these problems are not significant; however, additional dental or medical treatment may be necessary.

Local anesthetic may be used when these devices are inserted or removed, which also has risks. Please advise the doctor placing the device if you have had any difficulties with dental anesthetics in the past.

If any of the complications mentioned above do occur, a referral may be necessary to your family dentist or another dental or medical specialist for further treatment. Fees for these services are not included in the cost for orthodontic treatment.

Patient or Parent/Guardian Initials

X _____

ACKNOWLEDGEMENT

I hereby acknowledge that I have read and fully understand the treatment considerations and risks presented in this form. I also understand that there may be other problems that occur less frequently than those presented, and that actual results may differ from the anticipated results. I also acknowledge that I have discussed this form with the undersigned orthodontist(s) and have been given the opportunity to ask any questions. I have been asked to make a choice about my treatment. I hereby consent to the treatment proposed and authorize the orthodontist(s) indicated below to provide the treatment. I also authorize the orthodontist(s) to provide my health care information to my other health care providers. I understand that my treatment fee covers only treatment provided by the orthodontist(s), and that treatment provided by other dental or medical professionals is not included in the fee for my orthodontic treatment.

Patient Name X _____

Date: _____

X _____

Signature of Patient/Parent/Guardian

Signature of Witness

CONSENT TO UNDERGO ORTHODONTIC TREATMENT

I hereby consent to the making of diagnostic records, including x-rays, before, during and following orthodontic treatment, and to the above doctor(s) and, where appropriate, staff providing orthodontic treatment prescribed by the above doctor(s) for the above individual. I fully understand all of the risks associated with the treatment.

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I hereby authorize the above doctor(s) to provide other health care providers with information regarding the above individual's orthodontic care as deemed appropriate. I understand that once released, the above doctor(s) and staff has (have) no responsibility for any further release by the individual receiving this information.

CONSENT TO USE OF RECORDS

I hereby give my permission for the use of orthodontic records, including photographs, made in the process of examinations, treatment and retention for purposes of professional consultations, research, education, or publication in professional journals.

Date: _____

Signature of Patient/Parent/Guardian

Signature of Witness

Other Notes: _____



Results of Treatment

Orthodontic treatment usually proceeds as planned, and we intend to do everything possible to achieve the best results for every patient. However, we cannot guarantee that you will be completely satisfied with your results, nor can all complications or consequences be anticipated. The success of treatment depends on your cooperation in keeping appointments, maintaining good oral hygiene, avoiding loose or broken appliances, and following the orthodontist's instructions carefully.

Length of Treatment

The length of treatment depends on a number of issues, including the severity of the problem, the patient's growth and the level of patient cooperation. The actual treatment time is usually close to the estimated treatment time, but treatment may be lengthened if, for example, unanticipated growth occurs, if there are habits affecting the dentofacial structures, if periodontal or other dental problems occur, or if patient cooperation is not adequate. Therefore, changes in the original treatment plan may become necessary. If treatment time is extended beyond the original estimate, additional fees may be assessed.

Discomfort

The mouth is very sensitive so you can expect an adjustment period and some discomfort due to the introduction of orthodontic appliances. Nonprescription pain medication can be used during this adjustment period.

Relapse

Completed orthodontic treatment does not guarantee perfectly straight teeth for the rest of your life. Retainers will be required to keep your teeth in their new positions as a result of your orthodontic treatment. You must wear your retainers as instructed or teeth may shift, in addition to other adverse effects. Regular retainer wear is often necessary for several years following orthodontic treatment. However, changes after that time can occur due to natural causes, including habits such as tongue thrusting, mouth breathing, and growth and maturation that continue throughout life. Later in life, most people will see their teeth shift. Minor irregularities, particularly in the lower front teeth, may have to be accepted. Some changes may require additional orthodontic treatment or, in some cases, surgery. Some situations may require non-removable retainers or other dental appliances made by your family dentist.

Extractions

Some cases will require the removal of deciduous (baby) teeth or permanent teeth. There are additional risks associated with the removal of teeth which you should discuss with your family dentist or oral surgeon prior to the procedure.

Orthognathic Surgery

Some patients have significant skeletal disharmonies which require orthodontic treatment in conjunction with orthognathic (dentofacial) surgery. There are additional risks associated with this surgery which you should

discuss with your oral and/or maxillofacial surgeon prior to beginning orthodontic treatment. Please be aware that orthodontic treatment prior to orthognathic surgery often only aligns the teeth within the individual dental arches. Therefore, patients discontinuing orthodontic treatment without completing the planned surgical procedures may have a malocclusion that is worse than when they began treatment!

Decalcification and Dental Caries

Excellent oral hygiene is essential during orthodontic treatment as are regular visits to your family dentist. Inadequate or improper hygiene could result in cavities, discolored teeth, periodontal disease and/or decalcification. These same problems can occur without orthodontic treatment, but the risk is greater to individual wearing braces or other appliances. These problems may be aggravated if the patient has not had the benefit of fluoridated water or its substitute, or if the patient consumes sweetened beverages or foods.

Root Resorption

The roots of some patients' teeth become shorter (resorption) during orthodontic treatment. It is not known exactly what causes root resorption, nor is it possible to predict which patients will experience it. However, many patients have retained teeth throughout life with severely shortened roots. If resorption is detected during orthodontic treatment, your orthodontist may recommend a pause in treatment or the removal of the appliances prior to the completion of orthodontic treatment.

Nerve Damage

A tooth that has been traumatized by an accident or deep decay may have experienced damage to the nerve of the tooth. Orthodontic tooth movement may, in some cases, aggravate this condition. In some cases, root canal treatment may be necessary. In severe cases, the tooth or teeth may be lost.

Periodontal Disease

Periodontal (gum and bone) disease can develop or worsen during orthodontic treatment due to many factors, but most often due to the lack of adequate oral hygiene. You must have your general dentist, or if indicated, a periodontist monitor your periodontal health during orthodontic treatment every three to six months. If periodontal problems cannot be controlled, orthodontic treatment may have to be discontinued prior to completion.

Injury From Orthodontic Appliances

Activities or foods which could damage, loosen or dislodge orthodontic appliances need to be avoided. Loosened or damaged orthodontic appliances can be inhaled or swallowed or could cause other damage to the patient. You should inform your orthodontist of any unusual symptoms or of any loose or broken appliances as soon as they are noticed. Damage to the enamel of a tooth or to a restoration (crown, bonding, veneer, etc.) is possible when orthodontic appliances are removed. This problem may be more likely when esthetic (clear or tooth colored) appliances have been selected. If damage to a tooth or restoration occurs, restoration of the involved tooth/teeth by your

dentist may be necessary.

Headgears

Orthodontic headgears can cause injury to the patient. Injuries can include damage to the face or eyes. In the event of injury or especially an eye injury, however minor, immediate medical help should be sought. Refrain from wearing headgear in situations where there may be a chance that it could be dislodged or pulled off. Sports activities and games should be avoided when wearing orthodontic headgear.

Temporomandibular (Jaw) Joint Dysfunction

Problems may occur in the jaw joints, i.e., temporomandibular joints (TMJ), causing pain, headaches or ear problems. Many factors can affect the health of the jaw joints, including past trauma (blows to the head or face), arthritis, hereditary tendency to jaw joint problems, excessive tooth grinding or clenching, poorly balanced bite, and many medical conditions. Jaw joint problems may occur with or without orthodontic treatment. Any jaw joint symptoms, including pain, jaw popping or difficulty opening or closing, should be promptly reported to the orthodontist. Treatment by other medical or dental specialists may be necessary.

Impacted, Ankylosed, Unerupted Teeth

Teeth may become impacted (trapped below the bone or gums), ankylosed (fused to the bone) or just fail to erupt. Oftentimes, these conditions occur for no apparent reason and generally cannot be anticipated. Treatment of these conditions depends on the particular circumstance and the overall importance of the involved tooth, and may require extraction, surgical exposure, surgical transplantation or prosthetic replacement.

Occlusal Adjustment

You can expect minimal imperfections in the way your teeth meet following the end of treatment. An occlusal equilibration procedure may be necessary, which is a grinding method used to fine-tune the occlusion. It may also be necessary to remove a small amount of enamel in between the teeth, thereby "flattening" surfaces in order to reduce the possibility of a relapse.

Non-Ideal Results

Due to the wide variation in the size and shape of the teeth, missing teeth, etc., achievement of an ideal result (for example, complete closure of a space) may not be possible. Restorative dental treatment, such as esthetic bonding, crowns or bridges or periodontal therapy, may be indicated. You are encouraged to ask your orthodontist and family dentist about adjunctive care.

Patient or Parent/Guardian Initials

X

Date:

Please continue to the next page.....