PITTSBURGH ORTHODONTIC GROUP / Adolescent Patient Registration Form

Name _____ Date_____
Address_____
City_____ State _____ Zip _____
Home Phone _____ Date of Birth_____ Age _____ ☐ Male ☐ Female
School_____ Hobbies/Activities_____
Musical Instrument_____ Referred by _____
Siblings (Name/Age) _____
Patient's Dentist_____ Last visit _____

What would you like orthodontic treatment to accomplish? _____
Has another orthodontist been consulted or previous orthodontic treatment been provided? ☐ Yes ☐ No
If yes, what work has been completed and by whom? _____
Appointment reminders preference ☐ Email ☐ Text message ☐ Telephone call

PARENT'S INFORMATION

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐Separated ☐Other_____

Name _____
Address_____
City _____ State _____ Zip _____
Home phone _____ Cell Phone _____ Work Phone_____
Employer_____ Occupation _____ # Yrs._____
Date of Birth_____ Relationship to patient _____

Name _____
Address_____
City _____ State_____ Zip _____
Employer _____ Occupation_____ # Yrs. _____
Home Phone_____ Cell Phone_____ Work Phone_____
Date of Birth _____ Relationship to Patient _____

DENTAL INSURANCE

Insurance Company _____
Address_____
City _____ State _____ Zip _____ Phone _____
Subscriber/Member _____ Date of Birth_____
Member ID # _____ Member SSN _____

I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductibles that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure payment of benefits and I assign directly to this doctor all insurance benefits otherwise payable to me. I further authorize use of this signature on all my insurance submissions, manual or electronic.

✘_____

Signature *Date*

Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation.

For the following questions, please mark yes, no, or don't know/understand:

Yes No DK/U Does the patient follow directions?

Yes No DK/U Does the patient brush his/her teeth conscientiously?

Yes No DK/U Does the patient have learning disabilities/need extra help w/instructions?

Yes No DK/U Is the patient sensitive, self-conscious?

MEDICAL HISTORY

Yes No DK/U Birth Defects or hereditary problems?

Yes No DK/U Bones fractures or major injuries?

Yes No DK/U Rheumatoid or arthritic conditions?

Yes No DK/U Cancer, tumor, radiation treatment or chemotherapy?

Yes No DK/U Stomach ulcer or hyperacidity?

Yes No DK/U Diabetes or low sugar?

Yes No DK/U Kidney problems?

Yes No DK/U Endocrine or thyroid problems?

Yes No DK/U Problems of the immune system?

Yes No DK/U Polio, mononucleosis, tuberculosis, pneumonia?

Yes No DK/U AIDS or HIV positive?

Yes No DK/U Hepatitis, jaundice, or other liver problems?

Yes No DK/U Seizures, fainting spells, epilepsy, neurologic problems?

Yes No DK/U Mental health or behavioral problems?

Yes No DK/U Vision, hearing, or speech problems?

Yes No DK/U History of eating disorder (anorexia, bulimia)?

Yes No DK/U Frequent headaches or migraines?

Yes No DK/U High or low blood pressure?

Yes No DK/U Excessive bleeding or bruising, anemia?

Yes No DK/U Chest pain, shortness of breath, tire easily, swollen ankles?

Yes No DK/U Heart defects, heart murmur, rheumatic heart disease, angina, arteriosclerosis, stroke or heart attack?

Yes No DK/U Skin disorder (other than common acne)?

Yes No DK/U Does your child eat a well-balanced diet?

Yes No DK/U Loss of weight recently, poor appetite?

Yes No DK/U Frequent ear infections, colds, throat infections?

Yes No DK/U Asthma, sinus problems, hay fever?

Yes No DK/U Tonsil or adenoid condition?

Yes No DK/U Does your child frequently breathe through his/her mouth?

Yes No DK/U Allergies or drug reactions?

Yes No DK/U Is the patient taking medication, nutrient supplements or non-prescription medicine? Please list_____

_____

Yes No DK/U Does the patient currently have or ever had a substance abuse problem?

Yes No DK/U Surgical procedures? _____

Yes No DK/U Other physical problems or symptoms?

Yes No DK/U Being treated by another health care professional?

For _____

Date of most recent physical exam _____

DENTAL HISTORY

Yes No DK/U Started teething very early or late?

Yes No DK/U Primary (baby) teeth removed that were not loose?

Yes No DK/U Permanent or "extra" teeth (supernumerary) teeth removed?

Yes No DK/U Chipped or otherwise injured primary (baby) or permanent teeth?

Yes No DK/U Teeth sensitive to hot or cold; teeth throb or ache?

Yes No DK/U Jaw fractures, cysts, mouth infections?

Yes No DK/U 'Dead teeth', root canal treatment?

Yes No DK/U Bleeding gums, bad taste, mouth odor?

Yes No DK/U Food impaction between teeth?

Yes No DK/U Gum boils, frequent canker sores, cold sores?

Yes No DK/U Is child taking any form of fluoride?

Yes No DK/U Thumb, finger sucking habit? Until_____

Yes No DK/U Abnormal swallowing habit (tongue thrusting)?

Yes No DK/U History of speech problems?

Yes No DK/U Mouth breathing habit, snoring, difficulty in breathing?

Yes No DK/U Tooth grinding, jaw clenching, clicking, locking?

Yes No DK/U Any jaw pain or ringing in ears?

Yes No DK/U Does the patient experience any pain or soreness in the muscles of the face, or around the ears?

Yes No DK/U Difficulty in chewing or jaw opening?

Yes No DK/U Aware of loose, broken or missing retorations?

Yes No DK/U Any teeth irritating cheek, lip, tongue or palate?

Yes No DK/U Concerned about spaced, crooked, protruding teeth?

Yes No DK/U Aware or concerned about under or over developed jaw?

Yes No DK/U Any relative with similar tooth or jaw relationships?

Yes No DK/U Any wisdom tooth problems?

Yes No DK/U Has patient had any serious trouble associated with previous dental treatment?

Yes No DK/U Onset of puberty (approximate date) _____

Yes No DK/U Has patient had a prior orthodontic exam/treatment?

Yes No DK/U Has the patient recently been under a dentist's care?

Specialist_____

Other_____

Yes No DK/U Has the patient ever had periodontal (gum) treatment?

Yes No DK/U Would the patient object to wearing orthodontic appliances (braces) should they be indicated?

Date of most recent dental examination_____

How often does patient brush? _____Floss?_____

What is patient or parent's primary concern?_____

_____

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment? _____

_____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status I will so inform this practice.

Signature of parent or guardian ✗_____

Date_____

MEDICAL HISTORY CHANGE/UPDATE

Date	Comment	Signature

PATIENT NAME:_____ **DATE:**_____

TEMPOROMANDIBULAR JOINT AND FACIAL QUESTIONNAIRE

Please check all categories below – feel free to ask for assistance if you do not understand any question.

Yes	No	Questionnaire #1
____	____	Does your jaw make noise so that it bothers you or others?
____	____	Does your jaw get stuck as you try to open?
____	____	Does it hurt when you chew or open wide to take a big bite?
____	____	Do you have earaches or pain in front of the ears?
____	____	Do you have pain in the face, cheeks, jaws, throat or temples?
____	____	Is it difficult for you to open your mouth as far as you want to?
____	____	Do you suffer from frequent headaches?
____	____	Does your jaw "feel tired" after a big meal or dental visit?
____	____	Are you aware of an uncomfortable or bad bite?

Yes	No	Questionnaire #2
____	____	Are you aware that you grind your teeth at night or during the day?
____	____	Do you have a habit of clamping or clenching ("setting ") your teeth?
____	____	Do you have any jaw symptoms or headache upon waking in the morning?
____	____	Must you chew excessively on one side?
____	____	Have you had a blow to the jaw (trauma)?
____	____	Are you a habitual gum chewer or pipe smoker?

Yes	No	Questionnaire #3
____	____	Does the pain or discomfort disturb your sleep?
____	____	Does the pain or discomfort interfere with your daily routine or other activities?
____	____	Do you take medications or pills for pain or or discomfort? (pain relievers, muscle relaxants, antidepressant pills)
____	____	Does the pain or discomfort affect your appetite?
____	____	Do you feel the pain or discomfort extremely frustrating or depressing?

Yes	No	Questionnaire #4
____	____	Do you suffer from arthritis or pain in other joints?
____	____	Do you suffer from nervous stomach or ulcers?
____	____	Do you suffer from constipation? Colitis?
____	____	Do you suffer from back or neck pain (whiplash)?
____	____	Do you suffer from skin problems or allergies?
____	____	Have you ever been treated for a jaw joint disorder?

✘_____ _____

Signature Date

(Parent/Guardian of patient is a minor)

AREA FOR DOCTOR EXAM:

EXAM: _____

JOINT NOISE _____

MAX OPENING: _____

PAIN REPORTED: _____

CONSENT FOR THE ORTHODONTIC TREATMENT OF _____

In the vast majority of orthodontic cases, significant improvements can be achieved. While the benefits of a pleasing smile, face and healthy dentition are widely appreciated, orthodontic treatment like any other treatment of the body has some inherent risk and limitations. These are seldom that serious as to contra-indicate orthodontics, but should be considered in making the decision to undergo treatment. Please read the following information, ask us any questions that you may have, then (after you are completely satisfied with our explanations) consent to our treating you or your child by signing this form.

PATIENT COOPERATION - THE MOST IMPORTNAT FACTOR IN COMPLETING TREATMENT ON TIME.

The insufficient wearing of elastics, removable appliances, headgear or neck-strap; broken appliances and missed appointments, prevent our obtaining the desirable jaw growth anticipated. These are the factors that can lengthen treatment time and adversely affect the quality of treatment results.

DECALCIFICATION – TOOTH DISCOLORATION

The avoidance of chewing hard and sticky foods will keep bands and brackets from loosening. This and the reduction of sugar intake, reporting any loose bands as soon as they are noticed, will help minimize decay and gum problems. It is important to brush your teeth and gums immediately after eating. This will prevent decalcification, the white soft enamel areas that can become decay.

NONVITAL TOOTH - USUALLY THE RESULT OF AN INJURED TOOTH.

An injured tooth can die over a period of time with or without orthodontic treatment. This tooth may flare up during orthodontic movement and would require root canal treatment. Such discoloration of a tooth may be noticed after treatment has started or following appliance removal. Devitalization is seldom due to orthodontics.

NECK STRAP OR HEADGEAR – INSTRUCTION MUST BE FOLLOWED CAREFULLY.

Safety devices have been developed and are being used, but there is currently no foolproof device if a patient is careless; if a bow-arch is pulled out while the elastic force is attached, it can snap back and cause injury.

ROOT RESPORTION – SHORTENING OF ROOT ENDS.

This can occur with or without orthodontic treatment. Under healthy conditions the shortened roots are usually no problem. Injury, impaction, endocrine or idiopathic disorders can also be responsible.

IMPACED TEETH – TEETH UNABLE TO ERUPT NORMALLY

In attempting to move impacted teeth, especially cuspids, various problems are sometimes encountered which may lead to loss of the tooth or periodontal problems. The length of time required to move such a tooth can be vary considerably, Occasionally twelve year molars may be trapped under crowns of six year molars; consequently the removal of third molars may prove necessary.

TEMPORO- MANDIBULAR JOINTS (TMJ) - THE SLIDING HINGE CONNECTING THE UPPER & LOWER JAWS.

Possible problems may exist or occur during or following orthodontic treatment. Tooth position and bite can be a factor in this condition. An equilibration by your dentist may be recommended after appliances are removed to improve occlusal relationship. TMJ problems are not all "bite" related. Remember that most individuals that have a TMJ problem have never had orthodontic treatment.

GROWTH PATTERNS – FACIAL GROWTH OCCURRING DURING OR AFTER TREAMENT

Uncorrected finger, thumb, tongue, or similar pressure habits, unusual hereditary skeletal patterns, insufficient or undesirable growth can all influence our results; affect facial change and cause shifting of teeth during or following retention. Surgical procedures can frequently correct these problems. On a rare occasion it may be necessary to recommend a change in our original treatment plan.

RELAPSE – MOVEMENT OF TEETH FOLLOWING TREATMENT

Settling or shifting of teeth following treatment as well as after retention will most likely occur in varying degrees. Some of these changes may or may not be desirable. Rotations and crowding of lower anterior teeth are most common examples. Slight spaces in the extraction sights or between some upper anterior teeth are other examples. Sometimes we might advise the wearing of a retaining appliance every night or a few evenings each week for an indefinite period.

PERIODONTAL PROBLEMS – GUM INFLAMMATION, BLEEDING, AND PERIODONTAL DISEASE

Proper and regular flossing and brushing can usually prevent swollen, inflamed and bleeding gums. Periodontal disease can be caused by accumulation of plaque and debris around the teeth and gums, but there are several unknown causes that can lead to progressive loss of supporting bone and recession of the gums. Should the condition become uncontrollable, orthodontic treatment may have to be discontinued short of completion. This would be rare, usually in adults with pre-existing periodontal problems.

UNUSUAL OCCURRENCES

Swallowing an appliance, chipping a tooth, dislodging a restoration, an ankylosed tooth, an abscess or cyst may occur but these are rare.

DENTAL CHECK-UPS

All necessary dentistry must be completed prior to our starting orthodontic therapy. It is essential that the patient maintain their regular examinations with their family dentist every six months during the treatment period. Adults must visit their dentist, hygienist or periodontist for scaling and cleaning every three to five months while being treated.

Again, it is our intent to inform you of the myriad of possibilities that exist as potential problems. Most of these conditions occur rarely. There may be other inherent risks not mentioned. You should be aware that these things **COULD** happen. If any of these conditions should develop, every effort will be made to refer the patient to the appropriate therapist. Treatments of human biologic conditions will never reach a state of perfection despite technological advancements. Your treatment depends on a close professional working relationship. Patients should feel free to inquire about any aspect of theory treatment. Understanding and cooperation are essential for the results we both seek.

I CONSENT TO THE TAKING OF PHOTOGRAPHS AND X-RAYS BEFORE, DURING, AND AFTER THE TREATMENT, AND TO THE USE OF SAME BY THE DOCTOR IN SCIENTIFIC PAPERS OR DEMONSTRATIONS AND SOCIAL MEDIA.

I CERTIFY THAT I HAVE READ OR HAD READ TO ME THE CONTENTS OF THIS FORM AND DO REALIZE THE RISKS AND LIMITATIONS INVOLVED, AND DO CONSENT TO ORTHODONTIC TREATMENT.

PATIENT/PARENT/GUARDIAN: X _____ DATE: _____