NEW PATIENT

DAMON
ORTHODONTICS

Clay Damon, DDS
Paul Damon, DDS

North Office

4407 N Division St, Ste 722

Spokane WA 99207

509-484-8000

Valley Office

12406 E Mission Ave

Spokane Valley WA 99216

509-924-9860

South Office

4102 S Regal St, Ste 104

Spokane WA 99223

509-448-2600

Home of the
DAMON SYSTEM
PREMIER PROVIDER & STUDY CLUB LEADER

Member American Association of Orthodontists

GENERAL INFORMATION

Patient's Name _____ (Last / First / Middle / Preferred Nickname)

Address _____ (Street / City / State / Zip)

Home Phone _____ DOB _____ Age _____ Sex ❒ M ❒ F

Whom may we thank for referring you to our office? _____

Please describe the orthodontic problem in your words _____

List family members treated by Dr. Damon _____

IF PATIENT IS A MINOR

School _____ Grade _____

Special Interests: hobbies, sports, etc. _____

Parent's Marital Status ❒ Married ❒ Separated ❒ Divorced ❒ Widowed ❒ Single

Father's Name _____ (Last / First / Middle)

Address *(if different than above)* _____ (Street / City / State / Zip)

Home Phone *(if different than above)* _____ Work Phone _____

Social Security # _____ DOB _____ Cell Phone _____

Email _____

Employer / Position _____ How Long _____ (Yrs / Mo)

Mother's Name _____ (Last / First / Middle)

Address *(if different than above)* _____ (Street / City / State / Zip)

Home Phone *(if different than above)* _____ Work Phone _____

Social Security # _____ DOB _____ Cell Phone _____

Email _____

Employer / Position _____ How Long _____ (Yrs / Mo)

Patient lives with: ❒ Mother & Father ❒ Mother ❒ Father ❒ Other _____

Name of Step Parent(s) *(if applicable)* _____

IN CASE OF EMERGENCY CONTACT

Name _____ Relationship _____

Home Phone _____ Work Phone _____

IF PATIENT IS AN ADULT

Social Security # _____ Work Phone _____

Email _____ Cell Phone _____

Employer _____ Occupation _____

Spouse's Name _____ (Last / First / Middle)

Address *(if different than above)* _____ (Street / City / State / Zip)

Home Phone *(if different than above)* _____ Work Phone _____

Social Security # _____ DOB _____ Cell Phone _____

Email _____

Employer / Position _____ How Long _____ (Yrs / Mo)

RESPONSIBLE PARTY, *if other than parent(s), or patient*

Name _____ (Last / First / Middle)

Address *(if different than above)* _____ (Street / City / State / Zip)

Home Phone *(if different than above)* _____ Work Phone _____

Social Security # _____ DOB _____ Cell Phone _____

Email _____ Relationship _____

Employer / Position _____ How Long _____ (Yrs / Mo)

Are there any cultural, learning or language barriers we need to be aware of? ❒ Yes ❒ No

Language: ❒ English ❒ Spanish ❒ Other _____ ❒ Translator Needed

Learning variables: ❒ None ❒ Hearing ❒ Vision ❒ Cognitive Impairment

PATIENT DENTAL HISTORY

Patient's Dentist _____

Has your dentist talked to you about an orthodontic concern? ❒ Yes ❒ No

Explain _____

Date of last dental cleaning/checkup: _____

Has all recommended dental work been completed? ❒ Yes ❒ No

Check if patient currently has or has had in the past:

❒ Extra teeth
❒ Missing teeth
❒ Gum disease or infection
❒ Herpes (fever blisters)
❒ High rate of tooth decay
❒ Teeth sensitive to hot, cold, or sweets
❒ Frequent canker sores
❒ Tooth extraction

Check all that apply to patient	Yes	*If yes, please explain*
Prior orthodontic evaluation		
Prior orthodontic treatment		
History of thumb / finger sucking		
History of nail biting		
Plays musical instrument		
Frequent headaches		
Had a severe injury to the head face, or teeth		
Noise or pain in jaw joint (TMJ)		
Treatment for a jaw joint problem		
History of clenching or grinding the teeth		

PATIENT MEDICAL HISTORY

Patient's Physician _____

Date of last medical exam _____

Check all that apply to patient	Yes	*If yes, please explain*
Under a physician's care		
Allergies		
Taking any medication(s)		List / Explain
Had an unfavorable reaction to any medication(s)		List
Mentally or physically challenged		
Requires antibiotic pre-medication for a dental appointment		

Please check any of the following which the patient has or has had:

❒ High blood pressure
❒ Heart Disease
❒ Rheumatic/Scarlet fever
❒ Heart murmur
❒ Bleeding problems/blood disorder
❒ Arthritis
❒ Bone disorders
❒ Prosthetic joint (replacement)
❒ Malignancies, tumors, cancers
❒ Liver problems/Hepatitis
❒ Tuberculosis
❒ Diabetes
❒ Tobacco use/Frequency _____
❒ Asthma
❒ Tonsils and/or Adenoids removed
❒ Mouth breathing/Snoring
❒ Sleep apnea
❒ Cleft lip and/or Cleft palate
❒ Speech problems/Speech therapy
❒ Hearing problems
❒ Epilepsy/Convulsions
❒ Nervous/Anxious
❒ Latex allergy
❒ Nickel/Metal allergy
❒ AIDS or HIV positive
❒ Bisphosphonate Medication

MINOR PATIENT GROWTH INFORMATION *(if known)*

Height of: Patient _____ Father _____ Mother _____

Patient's brothers and sisters:

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Has any member of the family had orthodontic treatment? If yes, who and where? _____

Please check any of the following which the patient has or has had:

Reached puberty (generally signaled by voice changing in boys and menstrual cycle in girls) ❒ Yes ❒ No

Growth or developmental disorder ❒ Yes ❒ No

Unusual growth rates ❒ Yes ❒ No

Family History of similar facial growth pattern ❒ Yes ❒ No

Are there any other dental or medical conditions of which we should be aware?

Authorization & Release

I understand and acknowledge I am financially responsible for any contracted treatment provided, regardless of insurance coverage. I have reviewed the information on this form, and it is accurate to the best of my knowledge. I understand that this information will be used by the orthodontist to help determine appropriate treatment. If there are any changes in my dental or medical status as reported on this form, I will inform Damon Orthodontics as the changes occur.

Signature _____ Date _____ Relationship _____

Printed Name _____ Patient Name _____

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

Notice of Privacy Practices: You have the right to read our *Notice of Privacy Practices* before you decide to sign this consent. By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations. ***A copy of our policy will be provided upon request.*** The following is a brief overview of how these policies are commonly applied in our office.

- A basis for planning for your care and treatment
- A means of communication among the many health professionals who contribute to your care
- A source of information for applying your diagnosis to your billing
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operation such as assessing quality and reviewing the competence of health care professionals

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Please Print Patient Name _____

Authorized Signature _____ Date _____

Please Print Name of Authorized Party _____

Relationship to Patient _____

DAMON ORTHODONTICS

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INFORMED ORTHODONTIC CONSENT

Patient Name _____

The first step in determining an orthodontic treatment plan is an initial evaluation and supporting diagnostic records including digital imaging as indicated. By signing below you are consenting to these procedures before, during, and after treatment and the use of the information by the doctor for scientific papers or educational demonstrations. Should treatment be recommended *and you accept* the treatment,your signature below serves as your consent to proceed with treatment. This consent does not create a financial obligation; it serves as an informed consent for treatment and does not *obligate* you to accept treatment.

Benefits of Orthodontic Treatment: The majority of orthodontic treatment plans are for functional and health related purposes. A beautiful attractive smile is a side benefit of the greater and more important benefit: healthy functional occlusion (how the teeth bite and work together.)

Limitations of Orthodontic Treatment: Variables such as growth, biological response, patient cooperation and/or habits, impacted teeth, and others beyond the orthodontist's control can affect the course, results, and/or stability of treatment. Lack of patient cooperation is the most common cause of extended treatment time and compromised treatment results. You agree to follow carefully all treatment instructions such as homecare and wearing elastics, and keep appointments as recommended by the orthodontist.

Post Treatment Tooth Movement: There is a likelihood that teeth will shift and settle after treatment. Some changes may be desirable, but others will not. Rotations and crowding of the lower anterior teeth are the most common examples. Slight spaces in an extraction site, missing tooth site, or between upper central teeth are also examples. Failure to wear retainers post treatment as instructed will likely result in unfavorable tooth movement relapse.

Risks of Orthodontic Treatment: Although it is not possible to identify every possible risk, the following are the most common: *Root Resorption:* (shortening of root ends) can occur with or without orthodontic treatment; however, under healthy conditions shortened roots do not pose a problem. Trauma, cuts, impaction, endocrine disorders or idiopathic reasons can cause root resorption. *Temporal Mandibular Joints (TMJ):* (the sliding hinge connecting the upper and lower jaws) problems may exist prior to or occur during orthodontic treatment. Tooth position can be a factor of this condition. An equilibration by your dentist and/or therapy may be recommended. *Unusual Occurrences:* such as chipping teeth, changing restorations, swallowing appliances, or accidents may occur at any time including during treatment. *Decalcification:*(discoloration of tooth enamel) or *Tooth Decay:* may be avoided by using proper oral hygiene, reducing sugar intake, and eating a healthy diet. *Non-Vital or Dead Tooth:* (tooth traumatized by a blow or other causes), a traumatized tooth can die over a period of time with or without orthodontic treatment. A tooth may flare up during orthodontic treatment and require endodontic treatment (root canal.) In other cases a tooth may have been so traumatized to the extent that it may not respond to orthodontic treatment. *Impacted Teeth:* (teeth unable to erupt normally) also may not respond to orthodontic treatment and may need to be surgically uncovered or extracted by an oral surgeon. Various problems with impacted teeth, especially cuspids, may be encountered which can lead to tooth or periodontal problems. *Recession:*(gum tissue reduction) can occur with or without orthodontic treatment and may require tissue grafting by a periodontist.

I certify that I have read, or had read to me, the contents of this document and do understand and accept that there are risks and limitations involved and do consent to orthodontic treatment.

Signed _____ Witness Initials _____

Relationship to Patient_____ Date _____

DAMON ORTHODONTICS

In order to assist you in determining your orthodontic insurance benefits, please complete Sections 1 and 3

SECTION 1

Name of Patient _____ Date of Birth _____

Name of Insured _____ Date of Birth _____

Address of Insured _____
Street City State Zip

Social Security # _____ Phone _____

Policy or Group # _____ Insured ID # _____

Employer Name _____ Phone _____

Dental Insurance Company Name _____

Dental Insurance Company Address _____

Dental Insurance Company Phone _____ ❒ Primary ❒ Secondary

SECTION 2 - *FOR OFFICE USE ONLY*

Date Checked _____ Checked by _____ Contact Person _____

Max Ortho Coverage $ _____ Lifetime -or- Yearly Paid _____ Deductible $ _____

Age Limit _____ Amount Used to Date $ _____

Pre Auth Required _____ ❒ We Bill ❒ Auto

Benefit Paid ❒ Monthly ❒ Quarterly ❒ 2 Pay ❒ Annual ❒ Other

_____

_____

_____

Accept Electronic Claims _____

Payor ID # _____

SECTION 3 - COMPLETE IF PATIENT HAS DUAL COVERAGE

Name of Patient _____ Date of Birth _____

Name of Insured _____ Date of Birth _____

Address of Insured _____
Street City State Zip

Social Security # _____ Phone _____

Policy or Group # _____ Insured ID # _____

Employer Name _____ Phone _____

Dental Insurance Company Name _____

Dental Insurance Company Address _____

Dental Insurance Company Phone _____ ❒ Primary ❒ Secondary

SECTION 4 - *FOR OFFICE USE ONLY*

Date Checked _____ Checked by _____ Contact Person _____

Max Ortho Coverage $ _____ Lifetime -or- Yearly Paid _____ Deductible $ _____

Age Limit _____ Amount Used to Date $ _____

Pre Auth Required _____ ❒ We Bill ❒ Auto

Benefit Paid ❒ Monthly ❒ Quarterly ❒ 2 Pay ❒ Annual ❒ Other

_____

_____

_____

Accept Electronic Claims _____

Payor ID # _____