STEWART Family Orthodontics

Dr. Charles Stewart, D.D.S.
1429 Clear Lake, Suite 300
Weatherford, TX 76086
(817) 341-2777
www.stewartortho.com

PATIENT HEALTH HISTORY

Patient Last Name	First Name	M.I.	Patient Date of Birth	Patient SSN

Address	City	State	Zip	Phone

Party Responsible or Guardian	Phone	Email	DL# Rep Party	SSN of Rep Party

Employer Name	Position	Business Phone

Nearest Relative not living with you	Address	Phone	Relationship

Dental Insurance No. 1	Group No.	Company Name	Policy Holder	SSN

Dental Insurance No. 2	Group No.	Company Name	Policy Holder	SSN

I authorize release of any information necessary to process dental claim.

I hereby authorize payment directly to the below-named Dentist of the Group Insurance Benefits otherwise payable to me.

Signed (patient or parent if minor) _____ Date _____

Signed (insured person) _____ Date _____

Referred By: ☐ Friend ☐ Dentist ☐ Yellow Pages ☐ Other: _____

Marital Status: _____ Name of general dentist: _____ Date of Last Dental Exam & Cleaning: _____

Yes	No	Have you ever had any of the following:
☐	☐	Hepatitis
☐	☐	Liver Disease
☐	☐	Epilepsy convulsions
☐	☐	Seizures
☐	☐	Rheumatic Fever
☐	☐	Kidney Disease
☐	☐	Bladder Disease
☐	☐	Diabetes
☐	☐	Tuberculosis
☐	☐	Emphysema
☐	☐	Asthma
☐	☐	Shortness of Breath
☐	☐	Swollen Ankles
☐	☐	Chest Trouble
☐	☐	High/Low Blood Pressure
☐	☐	Stroke
☐	☐	Thyroid Trouble
☐	☐	Psychiatric Treatment
☐	☐	Arthritis
☐	☐	Rheumatism
☐	☐	Venereal Disease
☐	☐	Glaucoma
☐	☐	Chemotherapy/Radiation
☐	☐	Sinus Problems/Hay Fever/Allergies
☐	☐	Problem at Birth
☐	☐	Heart Murmur
☐	☐	Sickle Cell Anemia
☐	☐	Bleeding/ Hemophilia
☐	☐	Blood Transfusion
☐	☐	AIDS or HIV Positive
☐	☐	Cancer
☐	☐	Cleft Lip/Palate
☐	☐	Speech Problems
☐	☐	Hearing Problems
☐	☐	Eye Problems/ Contact Lenses
☐	☐	Tonsil/Adenoid Problems

Yes	No	If you are female, are you:
☐	☐	Pregnant
☐	☐	Taking Birth Control Pills
☐	☐	Taking Hormone Medication

Circle either Yes or No

Are you presently under the care of a physician?
YES / NO if yes, for what and date of last office appointment:

_____

_____

Have you ever been told that you are allergic to a drug?
YES / NO or have you ever had a bad reaction to a drug?
YES / NO if yes, to either, which drug?

_____

_____

Have you ever had a bleeding problem?
YES / NO
Have you ever had trouble with an extraction?
YES / NO if yes to either, please explain.

_____

_____

Are you presently taking any Drugs or Medications?
YES / NO If yes, please list:

_____

_____

Yes	No	
☐	☐	Do you have difficulty in opening your mouth widely?
☐	☐	Have you ever received a severe blow to your head or jaw?
☐	☐	Does it cause pain to open your jaw widely?
☐	☐	Do you ever hear popping or clicking sounds from your jaw joints?
☐	☐	Are you presently in any pain from your jaw joints or muscles?
☐	☐	Are you taking any tranquilizers, muscle relaxants, or antidepressants?

What is the main problem that brought you to our office?

_____

_____

_____

_____

Please add anything about your medical or dental history you feel is important for us to know about:

_____

_____

_____

_____

Doctor's Signature: _____ Date: _____

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CONSENT

For orthodontic treatment of _____ Date _____

Orthodontic treatment remains an elective procedure. It, like any other treatment of the body, has some inherent risk and limitations. These seldom prevent treatment, but should be considered in making the decision to undergo treatment.

PREDICTABLE FACTORS
THAT CAN AFFECT THE OUTCOME OF ORTHODONTIC TREATMENT:

COOPERATION: In the vast majority of orthodontic cases, significant improvements can be achieved with patient cooperation.

Excessive treatment time and/or compromised results can occur from non-cooperation.

CARING for APPLIANCES – Poor tooth brushing increases the risk of decay when wearing braces. Excellent oral hygiene, reduction in sugar, being selective in diet and reporting any loose bands as soon as noticed, will help minimize decay, white spots (decalcification) and gum problems. Routine visits (3 – 6 months) to your dentist for cleaning and cavity checks are necessary.

WEARING RETRACTOR (headgear) and ELASTICS – These are forces placed on teeth so they will move into their proper positions. The amount of time worn affects results. Wear as instructed! If headgear is detached from the tubes or arch wire hooks while the elastic force is engaged, it can snap back and cause injury.

KEEPING APPOINTMENTS – Missed appointments create many scheduling problems and lengthen treatment time.

UNPREDICTABLE FACTORS
THAT CAN AFFECT THE OUTCOME OF ORTHODONTIC TREATMENT:

MUSCLE HABITS – Mouth breathing, thumb, finger, or lip sucking, tongue trusting (abnormal swallowing) and other unusual habits can prevent the teeth from moving to their corrected positions or relapse after braces are removed. Orthodontics may deprogram the bite and the bite may become worse with orthodontic treatment.

FACIAL GROWTH PATTERNS – Unusual skeletal patterns and insufficient or undesirable facial growth can compromise the dental results, affect a facial change and cause shifting of teeth during retention. Surgical assistance may be recommended in these situations.

POST TREATMENT TOOTH MOVEMENT – Teeth have a tendency to shift or settle after treatment, as well as after retention. Some changes are desirable, others are not. Rotations and crowding of the lower anterior teeth or slight space in the extraction site or between the upper centrals are common examples.

TEMPOROMANDIBULAR PROLEMS (TM) – Possible TM problems may develop with this sliding joint on which the lower jaw moves either before, during or after orthodontic treatment. Tooth position, bite or non-symptomatic, pre-existing TM problems can be a factor in this condition. An equilibration (selective smoothing or reshaping the tooth) or other special treatment may be recommended by your dentist to improve occlusal or joint relationship.

IMPACTED TEETH – In attempting to move impacted teeth (teeth unable to erupt normally), especially cuspids and third molars (wisdom teeth), various problems are sometimes encountered which may lead to periodontal problems, relapse, or loss of teeth.

ROOT RESORPTION – Shortening of root ends can occur when teeth are moved during orthodontic treatment. Under healthy conditions the shortened roots usually are no problem. Trauma, impaction, endocrine disorders or idiopathic (unknown) reasons also cause this problem. Severe resorption can increase the possibility of premature tooth loss.

NONVITAL OR DEAD TOOTH – A tooth traumatized by a blow or other causes can die over a long period of time with or without orthodontic treatment. This tooth may discolor or flare up during orthodontic movement and require endodontic treatment – (root canal).

PERIODONTAL PROBLEMS (GUM DISEASE) – This condition can be present before or develop during treatment. It could deteriorate during treatment causing loss of bone around the teeth. Excellent oral hygiene and frequent prophylaxis by your dentist can help control this situation.

UNUSUAL OCCURRENCES – Swallowing appliances, chipping teeth, dislodging restorations.

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

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

_____
WITNESS

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ORTHODONTIC INSURANCE INFORMATION

Please bring your insurance card and know your orthodontic coverage prior to your appointment or it may delay the filing of your insurance benefit. Call your Insurance carrier or Human Resources representative with any questions.

PATIENT INFORMATION:

Patient's First Name:_____ M.I.:_____ Last Name:_____

Date of Birth (MM/DD/YYYY):_____ Sex: ☐ Male ☐ Female

Relationship to the Insured: ☐ Self ☐ Child ☐ Spouse ☐ Other:_____

NOTE: If you have a 2nd Insurance in effect at the time of your consult, and it is not presented at that time; it may result in a contract change (higher or lower) which could result in a change to your monthly payment.

SUBSCRIBER INFORMATION:

Subscriber's First Name:_____ M.I.:_____ Last Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Subscriber Identifier (SSN or ID#):_____ Date of Birth (MM/DD/YYYY):_____

Employer Name:_____

Employer City:_____ Employer Phone Number:_____

INSURANCE INFORMATION:

Insurance Carrier:_____

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

1-800 Phone Number of Insurance Co.:_____

Plan/Group Number:_____ Effective Date:_____

Lifetime Maximum:_____ Payable at:_____%

If you are an adult, do you have adult ortho Insurance?	☐ Yes	☐ No
Do you need a referral from your primary dentist?	☐ Yes	☐ No
Do you have a second insurance?	☐ Yes	☐ No
Do you have another family member in treatment with us?	☐ Yes	☐ No
Is there a waiting period for ortho?	☐ Yes	☐ No
Have you used any of your ortho benefits?	☐ Yes	☐ No

For Office Use Only

Consult _____ Ded _____ Pre-existing _____

Banding _____ Pay's ___ M___ Q ___ Auto_____ Used _____

Extractions included in ortho max ___ Age Limits _____

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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

_____
Patient Name

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Name: _____ Social Security # _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of 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.

For Office Use Only

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

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

_____

_____

STEWART
Family Orthodontics

Your Name:_____

Thank you for visiting our office. Please take a minute and let us know how you found out about us by checking a box below. Thanks!

- ☐ Doctor Referral
  - o Doctor's name:_____
- ☐ Yellow Pages
  - o Yellowbook, Yellow Pages, or Area-Wide
- ☐ One of our patients referred you
  - o Patient's name:_____
- ☐ Search Engine (Google, Yahoo, Bing, etc)
  - o Name of search engine:_____
- ☐ Our Website www.StewartOrtho.com
- ☐ Facebook
- ☐ Family member is or was in treatment with us
  - o Name:_____
- ☐ Insurance
  - o Insurance provider_____
- ☐ Other
  - o Please Specify_____

Texas

We will take reasonable steps to provide free-of-charge language assistance services to people who speak languages we are likely to hear in our practice and who don't speak English well enough to talk to us about the dental care we are providing.

Spanish:
Tomaremos acciones razonables para proporcionar servicios de asistencia lingüística gratuitos a aquellas personas cuyo lenguaje escuchemos frecuentemente en nuestro consultorio y que no hablen un inglés lo suficientemente bueno como para hablar con nosotros sobre el servicio odontológico que suministramos.

Vietnamese:
Chúng tôi sẽ thực hiện các bước cần thiết để cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho những người giao tiếp bằng những ngôn ngữ mà chúng tôi có thể nghe thấy tại phòng khám của mình và cho những người không có đủ trình độ tiếng Anh để thảo luận về dịch vụ chăm sóc nha khoa mà chúng tôi đang cung cấp.

Chinese:
我们将有序地做到提供免费的语言服务使我们能听懂英语不好的人向我们咨询有关牙齿护理

Korean:
저희는 적절한 조치를 통하여 언어 지원 서비스를 무료로 제공할 것입니다. 다만, 실제로 저희에게 관심이 있는 언어를 쓰지만 저희 치아 관리 서비스에 대해 의견을 줄 수 있을 만큼 영어로 의사소통이 원활하지 않는 경우로 한정합니다

Arabic:
سوف نقوم باتخاذ خطوات معقولة من أجل توفير خدمات المساعدة اللغوية بدون تكلفة للأشخاص الذين يتحدثون لغات أخرى من المرجح أن نستمع إليها خلال ممارستنا والذين لا يتقنون تحدث الإنجليزية بشكل جيد يمكنهم من التحدث إلينا فيما يتعلق برعاية الأسنان التي نقدمها.

Urdu:
ہم ان لوگوں کو جو ہماری پیش کردہ زبان بولتے ہیں لیکن انگریز ی نہیں جانتے اور ہم سے ڈینٹل کیر کے لیے بات کرتے ہیں مفت زبان دانی کی امداد کے لیے معقول اقدام اٹھائیں گے۔

Tagalog:
Gagawin namin ang mga makatwirang hakbang para maibigay namin ng walang bayad ang mga tulong na serbisyo sa wika para sa mga taong nagsasalita ng mga wikang karaniwan naming naririnig sa aming pagsasagawa at sa mga hindi bihasa sa pagsasalita ng Ingles na sasangguni sa amin tungkol sa pangangalaga ng ngipin na ibinibigay namin.

French:
Nous prendrons les mesures raisonnables pour fournir des services d'assistance linguistique gratuits pour les individus qui parlent des langues que nous sommes susceptibles d'entendre durant nos séances et qui ne parlent pas suffisamment bien l'anglais pour discuter avec nous concernant les soins dentaires que nous fournissons.

Hindi:
हम उन व्यक्तियों को, जो कि ऐसी भाषाएं बोलते हैं जो हम अपने अभ्यास में संभावित रूप में सुनना चाहते हैं और जो हमारे द्वारा प्रदान की जाने वाली डैंटल देखभाल के बारे में हमारे साथ उचित ढंग से अंग्रेज़ी नहीं बोलते, मुफ़्त सेवाएं प्रदान करने के लिये उचित कदम उठायेंगे।

Persian (Farsi):

ما برای ارائه خدمات ترجمه رایگان به افرادی که زبان انگلیسی آنها برای صحبت با ما درباره خدمات مراقب از دندان ارایه شده ما در حد کافی نبوده و به زبان های صحبت می کنند که ما به احتمال زیاد در هنگام کار با آنها سر و کار پیدا می کنیم گام هایی منطقی را بر خواهیم داشت.

German:

Wir werden angemessene Schritte unternehmen, um denen eine gebührenfreie Sprachunterstützung zu bieten, die Sprachen sprechen, die wir möglicherweise in unserer Praxis hören, die aber kein Englisch sprechen, das gut genug ist, um mit uns über die Zahnpflege zu sprechen, die wir anbieten.

Gujarati:

અમે એવા લોકોને વિના મૂલ્યે ભાષા સહાય સેવા પૂરી પાડવા ઉચિત પગલાં લઇશું

જેઓ એ ભાષાઓ બોલે છે જે અમને (તબીબી) પ્રેકટીસમાં સાંભળવા મળી શકે અને

જેઓ અમે જે દંત સુરક્ષા પ્રદાન કરીએ છીએ તેના વિષે વાત કરવા પૂરતું યોગ્ય ઇંગ્લીશ બોલી શકતા નથી.

Russian:

Мы принимаем необходимые меры, чтобы предоставить бесплатные услуги переводчика для общения на языках, с которыми мы сталкиваемся в нашей практике с клиентами, которые не владеют английским языком достаточно, чтобы обсудить с нами стоматологическое обслуживание, которое мы предоставляем.

Japanese:

実際に練習の中で耳にするく可能性がある言語を話す人々で、弊社が提供している歯科治療について、英語がそれほど上手でない人々に、無償の言語支援サービスを提供するために合理的な措置を講じるつもりです。

Laotian:

ພວກເຮົາຈະໃຊ້ຂັ້ນຕອນທີ່ເໝາະສົມ
ເພື່ອໃຫ້ບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາບໍ່ເສຍຄ່າແກ່ຄົນຜູ້ທີ່ເວົ້າພາສາທີ່ພວກເຮົາອາດຈະໄດ້ຍິນຢູ່ໃນການຝຶກຊ້ອມຂອງພວກເ
ຮົາ ແລະ ຜູ້ທີ່ບໍ່ເວົ້າພາສາອັງກິດໄດ້ດີພໍ ເພື່ອລົມກັບພວກເຮົາກ່ຽວກັບການບໍລິແຍງດູແລແຂ້ອທີ່ພວກເຮົາກໍາລັງຈັດໃຫ້.

Discrimination is Against the Law

Stewart Family Orthodontics
complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Stewart Family Orthodontics
does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Stewart Family Orthodontics:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Laurie Batson

If you believe that Stewart Family Orthodontics
has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html