

Date \_\_\_\_\_

Patient's name \_\_\_\_\_

Address \_\_\_\_\_  
Street City Zip

Home Phone \_\_\_\_\_ Birthday \_\_\_\_\_ Social Security \_\_\_\_\_

Patient Cellular Phone \_\_\_\_\_ Would you like a text message reminder sent to this number? YES or NO

Whom may we thank for referring you to our office? \_\_\_\_\_

Dentist \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

Name \_\_\_\_\_

Mailing Address \_\_\_\_\_  
Street City Zip

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Cell/other phone \_\_\_\_\_ Would you like a text message reminder sent to this number? YES or NO

Email address \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthday \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

**MEDICAL HISTORY: Circle any of the medical conditions below that you have had or currently have.**

- |                |                     |                     |                    |
|----------------|---------------------|---------------------|--------------------|
| Aids           | Chest Pains         | Fainting, Dizziness | Nervous Disorders  |
| Allergies      | Chronic Neck Pain   | Headaches           | Organ Transplant   |
| Anemia         | Cold Sores/Herpes   | Heart Condition     | Pregnant           |
| Arthritis      | Diabetes            | Hepatitis           | Prolonged Bleeding |
| Asthma         | Drug Allergies      | Immune Problems     | Rheumatic Fever    |
| Autoimmune     | Endocrine Problems  | Kidney Problems     | Scoliosis          |
| Bone Disorders | Emotional Disorders | Low Blood Pressure  | Seizures           |
| Cerebral Palsy | Epilepsy            | Muscular disorders  | Speech Problems    |

Any disease, problem or allergies not mentioned above: \_\_\_\_\_

Current Medications: \_\_\_\_\_ Have you started Menstruating/Age: \_\_\_\_\_

**DENTAL HISTORY: Circle any of the conditions below that you have or currently have.**

- |                            |                                 |                          |
|----------------------------|---------------------------------|--------------------------|
| Wisdom teeth extracted     | Face, mouth, teeth injuries     | Mouth breathing          |
| Painful Chewing            | Missing or Extra Teeth          | Snoring                  |
| TMJ Problems               | Gums bleed( brushed or flossed) | Tonsils/Adenoids Removed |
| Thumb sucking/digit issues |                                 |                          |

Previous Orthodontics: \_\_\_\_\_ Other questions? \_\_\_\_\_

Brother/Sisters Names and Ages \_\_\_\_\_

WE ARE SORRY THAT WE CANNOT ACCEPT DIVORCE DECREES AS ASSIGNMENTS OF RESPONSIBILITY FOR A CHILD'S ORTHODONTICS BILLS. THE PARENT ACCOMPANYING THE CHILD SHOULD PAY FOR THE SERVICES AND SEED ANY REIMBURSEMENT FROM THE OTHER PARENT. TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND CORRECT. I, THE UNDERSIGNED, AGREE TO PAY FOR ATTORNEY FEES AND OTHER COSTS OF COLLECTIONS IN THE EVENT IT BECOMES NECESSARY TO USE ATTORNEY SERVICES TO SECURE PAYMENT OF THIS ACCOUNT.

Signature: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by Dr. Henry G. Griggs, Jr. : \_\_\_\_\_

## Orthodontics Insurance Verification

**Please have all information filled out BEFORE your appointment.**

Dental Insurance Company phone number is located on your Insurance Card  
Currently **Medicaid** and **ALL Kids** do not offer orthodontic benefits

Patient Name: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's Social Security \_\_\_\_\_

Date of Birth \_\_\_\_\_ Employer \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Phone No. \_\_\_\_\_

Do you have dual coverage? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes:

Insured's Name \_\_\_\_\_ Insured's Social Security \_\_\_\_\_

Date of Birth \_\_\_\_\_ Employer \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Phone No. \_\_\_\_\_

**PLEASE ASK YOUR INSURANCE COMPANY REPRESENTATIVE THE FOLLOWING QUESTIONS:**

What is the effective date of my orthodontic coverage? \_\_\_\_\_

What is the lifetime orthodontics maximum covered? \_\_\_\_\_

At what percentage is the benefit paid? Paid @ \_\_\_\_\_% (Usually 50%)

Deductible?  Yes  No If yes, annual or lifetime.(circle one) Amount: \_\_\_\_\_

Are orthodontic benefits paid automatically?  Yes  No

If the benefit is not paid automatically, how is it paid? Check below:

Monthly: \_\_\_\_\_ Quarterly: \_\_\_\_\_ Annually: \_\_\_\_\_ Semi Annually: \_\_\_\_\_

Do you pay out-of-network benefits? \_\_\_\_\_

Is there a waiting period?  Yes  No

Is there an age limit?  Yes  No If so what age: \_\_\_\_\_

Verified by: (name of person from insurance company you spoke with): \_\_\_\_\_

Date: \_\_\_\_\_

If this was an automated call, please initial: \_\_\_\_\_ Date: \_\_\_\_\_

# Henry G. Griggs Jr., D.M.D., M.S., LLC

## INFORMED CONSENT

### **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 each 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.

## 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 an 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.

## 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 the 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.**

**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.

\_\_\_\_\_  
Signature of Patient/Parent/Guardian

**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.

\_\_\_\_\_  
Signature Date

I have the legal authority to sign this on behalf of  
~

**Social Media Consent**

I hereby give Henry G. Griggs Jr. D.M.D., M.S., L.L.C. permission to take photographs of me for the purpose of posting on social media sites, emailed news letters, and in office contests. I hereby release and discharge Henry G. Griggs Jr. D.M.D., M.S., L.L.C. from any and all claims arising out of use of the photos.

\_\_\_\_\_  
Signature Date

Henry G. Griggs, Jr., D.M.D., M.S., L.L.C.

*Specialist in Orthodontics*

## **PRIVACY POLICY**

**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.**

Your protected health information (i.e. individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographics 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 cleaning, 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.);
- To certify, licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- 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 alternatives or other health-related benefits and services that may of interest to you.

Any other use or disclosures of your protected health information will be made only your written authorization, which you have the right to revoke.

Under the new privacy rule, you have the right to:

- Request restrictions on the use and disclosures 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 and 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 inquires to our Office Manager 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 to 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 this 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/or third party.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this notice, please direct your questions to our Office Manager. Thank you.

### **PATIENT ACKNOWLEDGEMENT**

\_\_\_\_\_  
**Patient Name**

\_\_\_\_\_  
**Signature of Patient/Responsible Party**

\_\_\_\_\_  
**Date**