WALL ORTHODONTICS

FACT:

"In an issue of the Journal of the American Dental Association (JADA) it was reported that 13-39% of all dental injuries are sports-related."

FACT:

"More than 5 million teeth are avulsed (knocked out) each year; many during sports activities, resulting in nearly $500 million spent on replacing these teeth each year."

Sports-Related Dental Injuries and Sports (Rick Knowlton, DMD, MAGD; Connie M. Kracher, PhD, MSD; Wendy Schmeling Smith, RDH, BSEd)

Hope this school year has been a great one for Tattnall County. I am contacting you to offer your team (s) athletic mouth guards at no cost to you, the school, or the parents. We always want to support the area schools and emphasize the importance of dental health to our youth. We see so many patients come in with chipped or totally avulsed teeth from sporting events and feel there is a community wide need.

We will be offering appointments for these mouth guards on Wednesdays during the summer from 8-12pm. All we ask is that parents call, ask for Amanda, and she will set up an appointment for his/her child! At the appointment we will make an individualized impression for the player followed by a group photo of your team with me at the time of mouth guard delivery a few weeks later.

Attached are the necessary Health History and HIPPA forms, which each parent will need to fill out and return at or before the appointment time. The children cannot be seen without the forms filled out by the parents.

Please let us know if this is something you and your school would be interested in doing. These mouth guards would be great for summer practice! We look forward to providing your students with individualized mouth guards to help maintain their dental health.

Thanks

MSWall

Mike Wall, DMD

CONFIDENTIAL INFORMATION
Date _____

UNDER 18
PATIENT INFORMATION FORM

Welcome to our Office…
Please assist us by completing the following questions…

Whom may we thank for your referral?_____

PATIENT INFORMATION				
Last Name	First	Middle		Preferred Name
Address				
City	State		Zip Code	
Home Phone	Date of Birth	Age	Sex: Male ☐ Female ☐	S.S.N.
Favorite Sports, Hobbies & Avocations				
School Attending		Grade	Musical Instrument(s) played	
Brothers/Sisters Name(s)	Age(s)			

RESPONSIBLE PARTY INFORMATION			
Name of Person Responsible for Account **EMAIL ADDRESS**			Relationship to Patient
Father's Name	Address *(If different from above)*		S.S.N.
Employed by		Work Phone	D.O.B.
Mother's Name	Address *(If different from above)*		S.S.N.
Employed by		Work Phone	D.O.B.

Do you have Dental Insurance? ☐ Yes ☐ No *(If Yes, please provide us with a copy of your insurance card)*

In case we cannot reach you, person(s) to contact	Phone Number

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing orthodontic treatment. All information will be kept completely confidential.

MEDICAL HISTORY

Physician's Name:_____
Address:_____ Phone: _____

Is the patient in good health? ☐ Yes ☐ No Explain:_____
Does the patient have a history of a major illness? ☐ Yes ☐ No Explain:_____
Is the patient under the care of a physician? ☐ Yes ☐ No Explain:_____
Is the patient taking any medications? ☐ Yes ☐ No List:_____ _____

Does the patient take any pre-medication prior to dental procedures? ☐ Yes ☐ No List:_____

Is the patient allergic to: ☐ penicillin ☐ codeine ☐ local anesthetics ☐ banthine ☐ other drugs _____ ☐ foods_____

****Is the patient allergic or sensitive to any metals or other products (i.e. latex, nickel)? ☐ Yes ☐ No List:_____**

Has the patient had surgery that involves the placement of a prosthesis (i.e. hip/knee replacement, heart valve, etc..)? ☐ Yes ☐ No Describe:_____
Has the patient had surgery or radiation treatment for a tumor or growth in the head and neck area? ☐ Yes ☐ No Describe:_____

Onset of puberty (approximate date)? _____

Patient's Height_____ Patient's Weight_____ Mother's Height_____ Father's Height_____

Cont'd…please complete the reverse side

Please check if the patient has had any of the following conditions:

- ☐ HIV Positive/AIDS
- ☐ Hepatitis Type ____
- ☐ Liver Disease/Jaundice
- ☐ Rheumatic Fever
- ☐ Rheumatic Heart Dis.
- ☐ Scarlet Fever
- ☐ Heart Murmur/Defects
- ☐ Heart Trouble/Surgery
- ☐ Heart Valve Defects
- ☐ Tuberculosis
- ☐ High/Low BP
- ☐ Diabetes
- ☐ Bleeding Problems
- ☐ Lung Disease
- ☐ Epilepsy/Seizures
- ☐ Arthritis
- ☐ Lupus/CT Disease
- ☐ Kidney Disease
- ☐ Allergies
- ☐ Asthma/Lung Disease
- ☐ Cancer
- ☐ Anemia
- ☐ Glaucoma
- ☐ Degenerative Joints
- ☐ Thyroid Problems
- ☐ Venereal Disease
- ☐ Rheumatoid Arthritis
- ☐ Stomach Ulcers
- ☐ Gastric Reflux
- ☐ Polio
- ☐ Mononucleosis
- ☐ Substance Abuse
- ☐ Migraine Headaches
- ☐ Emotional Problems
- ☐ Stroke
- ☐ Frequent Headaches
- ☐ Endocrine Problems
- ☐ Nervous Disorders
- ☐ Bone Disorders
- ☐ Facial Pain
- ☐ Bulimia
- ☐ Anorexia Nervosa
- ☐ Muscular Disorder
- ☐ Fainting Spells
- ☐ Other_____

Comments:_____

_____

DENTAL HISTORY

Dentist's Name_____

Address:_____ Phone:_____

Please check any of the following conditions for which the patient has been diagnosed or treated:

- ☐ Facial/Teeth/Jaw Injury
- ☐ TMJ/TMD/Jaw Problems
- ☐ Grinding/Clenching Habit
- ☐ Jaw Clicking/Popping
- ☐ Jaw Locking
- ☐ Tongue Thrust
- ☐ Bleeding Gums
- ☐ Gum Recession
- ☐ Gum Disease
- ☐ Lip Habit
- ☐ Dead Teeth/Root Canal
- ☐ Tooth Sensitivity
- ☐ Chipped or Broken Teeth
- ☐ Thumb or finger habit
- ☐ Facial Pain
- ☐ Ringing in the Ears
- ☐ Cold Sores
- ☐ Mouth Ulcers
- ☐ Jaw Cysts/Tumors
- ☐ Missing Teeth
- ☐ Mouth Breathing
- ☐ Impacted Teeth
- ☐ Receding Jaw
- ☐ Other_____
- ☐ Other_____

COMMENTS:_____

_____

Which of the following are significant concerns?

- ☐ Crooked/Crowded Teeth
- ☐ Impacted Teeth
- ☐ Spaced Teeth
- ☐ Under Developed Jaw
- ☐ Over Developed Jaw
- ☐ Tooth Wear
- ☐ Extra Teeth
- ☐ Wisdom Teeth
- ☐ Missing Teeth
- ☐ Protruding teeth
- ☐ Overbite
- ☐ Other_____

Has the patient had a prior orthodontic exam or prior orthodontic treatment? ☐ Yes ☐ No

Is the patient currently under a general dentist's care? ☐ Yes ☐ No

When was the patient's last dental exam and cleaning? _____

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?

If so please explain:_____

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

CONSENT FOR DIAGNOSTIC RECORDS

I consent to the taking of x-rays, models and photographs necessary for diagnostic purposes.

_____ _____

Signature of Parent or Guardian Date

INSURANCE AUTHORIZATION

I agree to be responsible for dental services and materials not paid by my dental benefit plan and to the extent permitted under applicable law, I authorize release of any information relating to this claim. I also hereby authorize payment of the dental benefits otherwise payable to me directly to Dr. Michael S. Wall, DMD.

_____ _____

Signature of Parent or Guardian Date

WALL
ORTHODONTICS

PHOTOGRAPH RELEASE CONSENT FORM

Patient Name: _____

I hereby authorize Wall Orthodontics, LLC to take photographs of me or my minor child, identified herein, and to use such photographs and/or my name or the name of said minor child in their printed publications, on their websites, and in other social media.

I acknowledge that the inclusion of the name and photograph of myself or my minor child identified herein in the printed publications, websites, or social media of Wall Orthodontics, LLC does not confer, upon either me or my minor child, any rights or ownership interest whatsoever in said publications, websites, or social media.

I hereby release Wall Orthodontics, LLC, its contractors, employees, and successors and assigns from any and all liability for any claims by me or any other third party on behalf of myself or my minor child in connection with the inclusion of the name or photograph of myself or my minor child in any printed publications, websites, or social media of Wall Orthodontics, LLC.

_____ _____

(Signature of Patient or Parent/Guardian of patient if a minor) (Date)

_____ _____

(Street Address) (Phone)

_____

(City, State, Zip)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT CONSENT FORM

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses of disclosure of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this content.

Patient Name: _____

Signature: _____ Date: _____

Relationship to Patient: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:	Initials:	Reason: