Rio Rancho Orthodontics
Randy G. Alkire, DDS, MS

New Patient Registration Form

Please fill out this form completely.

Today's Date _____

PATIENT INFORMATION

Patient's Name _____ Prefers to go by_____ ☐Male ☐Female
First M.I. Last

Address _____ SSN_____
Street City Zip

Birthdate_____ Age_____ School_____ Grade _____

Hobbies/Sports_____ Family members seen by us_____

How did you hear about our office? ☐Dentist ☐Insurance ☐Internet ☐Radio ☐Other_____

Who is accompanying the patient today? _____ Relationship_____

Do you have legal custody of this patient? ☐Yes ☐No If not, who does? _____

RESPONSIBLE PARTY & INSURANCE INFORMATION

1st PARENT or SELF or 1st GUARDIAN INFO

Name_____
Relationship to Patient_____
Address_____
City_____ State_____ Zip_____
How long at this address? _____
Phone #(s)_____
Email Address_____
Birthdate_____ SSN_____
Marital Status: ☐Married ☐Divorced ☐Single
Spouse's Name _____

Employer_____
Occupation_____ #Years _____
Primary Insurance Company _____
Insurance Address_____
Insurance City_____ State_____
Insurance Phone #_____
Group #_____
Insurance I.D. #_____

2nd PARENT or SPOUSE or 2nd GUARDIAN INFO

Name_____
Relationship to Patient_____
Address_____
City_____ State_____ Zip_____
How long at this address? _____
Phone #(s)_____
Email Address_____
Birthdate_____ SSN_____
Marital Status: ☐Married ☐Divorced ☐Single
Spouse's Name _____

Employer_____
Occupation_____ #Years _____
Secondary Insurance Company _____
Insurance Address_____
Insurance City_____ State_____
Insurance Phone #_____
Group #_____
Insurance I.D. #_____

Responsible Party Signature_____ Date_____

MEDICAL HISTORY

Patient's Physician_____ Phone #_____ Date of last visit_____

Please check Yes or No to the following (If Yes, please fill in details):

☐Yes ☐No Is the patient taking any medications? _____

☐Yes ☐No Is the patient allergic to any medications? _____

☐Yes ☐No Does the patient have a history of any major illness? _____

☐Yes ☐No Has the patient had any operations/stays in the hospital? _____

☐Yes ☐No Has the patient ever been involved in a serious accident? _____

☐Yes ☐No Does the patient have any learning disabilities or need extra help with instructions? _____

☐Yes ☐No Does the patient chew or smoke tobacco? _____

Female Patients Only:

☐Yes ☐No Has menstruation started? _____

☐Yes ☐No Is the patient pregnant? If yes, how many weeks? _____

Please check any of the following medical conditions below that the patient has had or currently has:

☐Abnormal bleeding/Hemophilia	☐Rheumatic Fever	☐Kidney problems
☐Anemia/Fainting/Dizziness	☐Asthma/Emphysema	☐Bone disorders
☐Arthritis	☐Hepatitis/Liver problems	☐Allergies/Sinus problems
☐Stomach/Intestinal trouble	☐Tuberculosis	☐Cancer/Tumor/Chemotherapy
☐Heart attack/Stroke	☐Shingles/Herpes	☐HIV/AIDS
☐Diabetes	☐High/Low Blood Pressure	☐Nervous/Behavioral disorders
☐Seizures/Epilepsy	☐Pneumonia/Difficulty breathing	☐Drug/Alcohol abuse

Please expand upon any medical conditions that were selected above: _____

_____

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

_____

DENTAL HISTORY

Patient's General Dentist_____ Date of last visit_____

☐Yes ☐No Has the patient ever experienced any unfavorable reaction to previous dental work?_____

☐Yes ☐No Do the patient's gums bleed when brushing? _____

☐Yes ☐No Is any part of the patient's mouth sensitive to temperature or pressure? Where? _____

☐Yes ☐No Has the patient ever experienced jaw clicking, popping, or pain? _____

☐Yes ☐No Have there been any injuries to the face, mouth, or teeth? _____

☐Yes ☐No Has the patient had baby teeth removed that were not loose? _____

☐Yes ☐No Has the patient had permanent or extra teeth removed?_____

How many times a day does the patient brush his/her teeth? _____Does he/she floss daily? ☐Yes ☐No

Has the patient ever seen an orthodontist? ☐Yes ☐No If yes, who and when? _____

What are your main orthodontic concerns? _____

Does the patient have any of the following habits? (Please check all that apply):

☐Thumb/Finger sucking	☐Mouth breathing/snoring	☐Lip sucking/Biting	☐Speech problems
☐Clenching/Grinding teeth	☐Nail biting	☐Nursing bottle habit	☐Tongue thrust

Has anyone in the patient's family received orthodontic treatment? ☐Yes ☐No If yes, who? _____

What is the patient's attitude toward receiving orthodontic treatment? _____

***********Are you aware that some appointments will be during school or work hours? ☐Yes ☐No ***********

I have truthfully answered all of the above questions and agree to inform this office of any changes to the patient's medical/dental history. In addition, I authorize Dr. Randy G. Alkire to perform a complete orthodontic evaluation.

Responsible Party Signature_____ Date_____

Rio Rancho Orthodontics
Randy G. Alkire, DDS, MS

HIPAA Notice of Privacy Practices *Please read this form completely.*

THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment, or health care operations (TPO), and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "PHI" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition, and related health care services.

1. Uses and Disclosure of PHI:

Your PHI may be used and disclosed by your dentist, his office staff, and others outside of our office who is involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the dentist's practice and any other use required by law.

- **Treatment**: We will use and disclose your PHI to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your PHI may be provided to your general dentist to whom you have been referred in order to assure that he/she has the necessary information to diagnose or treat you appropriately.
- **Payment**: Your PHI will be used, as needed, to obtain payment for you health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for hospital admission.
- **Health Care Operations**: We may use or disclose, as needed, your PHI in order to support the business of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of dental students, licensing and conducting or arranging for other business activities. For example, we may disclose your PHI to dental school students who see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your dentist. We may also call you by name in the reception area when your dentist is ready to see you. We may use or disclose your PHI as necessary to contact you to remind you of your appointment. We may use or disclose your PHI in the following situations without your authorization, as required by law; communicable diseases, health oversight, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners, funeral directors and organ donation research, criminal activity, military activity and national security, worker's compensation, inmates, and required uses and disclosures. Also, under the law we must make disclosures to you and, when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirements of Section 164.500.
- **Appointment Reminders**: We may use and disclose dental information to contact you as a reminder that you have an appointment for treatment for dental care at Rio Rancho Orthodontics. The reminder may be by mail or as a telephone message.

Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. You may revoke this authorization at any time in writing, except to the extent that the dentist or dentist's practice has taken an action in reliance on the use or disclosure indication in the authorization.

2. Your Rights: The following is a statement of your rights with respect to your PHI.

- **The Right to Inspect and Copy Your PHI**: Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.
- **The Right to Request a Restriction to Your PHI**: This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care, or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restrictions to apply. Your dentist is not required to agree to any restriction that you may request. If the dentist believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another health care professional.
- **The Right to Request to Receive Confidential Communications from Us by Alternative Means or at an Alternative Location**: You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g. electronically.
- **The Right to Have Your Dentist Amend Your PHI**: If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement, and we will provide you with a copy of any such rebuttal.
- **The Right to Receive an Accounting of Certain Disclosures we have made, if any, of Your PHI**: We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided by this notice.

3. Complaints:

You may complain to us, or the Secretary of Health and Human Services, if you believe your privacy rights have been violated by Rio Rancho Orthodontics. You may file a complaint with us by submitting a written document to: Privacy Officer, Rio Rancho Orthodontics, 1316 Jackie Road SE, Suite 300, Rio Rancho, NM 87124. You will not be penalized for filing a complaint. This notice is effective on April 14, 2003, and will remain in effect until we replace it. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (505) 892-5749.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Responsible Party Signature_____ **Date**_____

Rio Rancho Orthodontics
Randy G. Alkire, DDS, MS

Informed Consent *for the Orthodontic Patient*

Risks and Limitations of Orthodontic Treatment

Please read this form completely.

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 orthodontist prior to the beginning of orthodontic 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. Non-prescription 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.

Responsible Party Initials_____

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 you 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 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 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.

Responsible Party Initials_____

Patient's Name_____**Date**_____

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 these 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 about 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) 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 Date

Signature of Orthodontist/Group Name Date

Witness Date

Responsible Party Initials _____

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 the 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 of Patient/Parent/Guardian Date

Witness Date

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

Name of Patient

Relationship to Patient

Notes: _____

_____

_____

_____

_____