WELCOME

CHILD INFORMATION

Please tell us a little about yourself

Your name _____ Preferred name _____ ▫Male ▫Female

Age _____ Birthdate _____ School _____ Grade _____

Address _____ City _____ State_____ Zip _____ Phone _____

Hobbies & interests _____

▫Yes ▫No Have you had previous orthodontic treatment? Please describe _____

_____

Are you interested in Invisalign or Braces (circle)? Please explain _____

_____

When are you interested in starting treatment? Please explain _____

_____

▫Yes ▫No Will you move anytime soon? Date _____ Please explain _____

_____

How did you hear about us? _____

FAMILY INFORMATION

FATHER

Name _____

Date of birth _____

Address _____

_____

How long at this address? _____ ▫Rent ▫Own

Work phone _____

Cell phone _____

E-mail address _____

Occupation _____ Years?_____

Employer _____

MOTHER

Name _____

Date of birth _____

Address _____

_____

How long at this address? _____ ▫Rent ▫Own

Work phone _____

Cell phone _____

E-mail address _____

Occupation _____ Years? _____

Employer _____

Are parents: ▫single ▫married ▫divorced ▫ separated

Does mom, dad and child all live together? ▫Yes ▫No Please explain _____

EMERGENCY contact _____ Phone _____ Relationship _____

Person responsible for account _____ Relationship _____

Responsible party signature _____ Date _____

CHILD'S INSURANCE INFORMATION

Primary Dental Insurance _____

Subscriber Name _____

Subscriber DOB _____

Subscriber ID# _____

Secondary Dental Insurance _____

Subscriber Name _____

Subscriber DOB _____

Subscriber ID# _____

CHILD'S HEALTH HISTORY

▫Yes ▫No Are you in good health? Please explain _____

Physician Name _____

▫Yes ▫No Have you been hospitalized or had operations? Please describe _____

_____

▫Yes ▫No Have you had tonsils and adenoids removed? At what age? _____

▫Yes ▫No Are you currently taking any medications? Please describe _____

▫Yes ▫No Have you begun puberty? at what age? Do you most resemble Mom or Dad? _____

▫Yes ▫No Do you have any allergies? Please explain _____

▫Yes ▫No Are you allergic to LATEX products (i.e. gloves, balloons) Please describe _____

▫Yes ▫No Do you have frequent colds, sore throat, canker sores? Please explain _____

▫Yes ▫No Do you have frequent headaches/muscle soreness around the head and neck? How do you treat the pain? _____

Have you been diagnosed or treated for any of the following? Please check ✔

▫ None ____ (initial)	▫ Convulsions	▫ Blood disorders	▫ Heart Trouble	▫ Drug allergy
▫ Diabetes	▫ Epilepsy	▫ Hepatitis	▫ High BP	▫ Venereal Disease
▫ Pneumonia	▫ Asthma	▫ Tuberculosis	▫ Fainting	▫ Osteoporosis
▫ Fever	▫ HIV+	▫ AIDS	▫ Herpes	
▫ Rheumatic Bone Disorders		▫ Endocrine problems		

Please list other medical or nonmedical conditions that may affect treatment _____

_____

CHILD'S DENTAL HISTORY

Name of General Dentist _____ Date of last visit _____

What was done? _____

▫Yes ▫No Are any teeth sore today? Please explain _____

▫Yes ▫No Have you had any injuries to the face, mouth or teeth? Please explain _____

_____

▫Yes ▫No Have you ever sucked your fingers or thumb? until what age? _____

▫Yes ▫No Do you breathe primarily through your mouth? _____

▫Yes ▫No Do you clench or grind your teeth? Please explain _____

▫Yes ▫No Is there clicking or pain upon opening or closing the mouth? Please explain _____

_____

I have read and agree to the "Notice of Privacy Practices," of Katherine M. Masaki D.D.S., M.S., which explains how my health and records can be used and disclosed.

Signature _____ Date _____

Thank you for providing the above information ☺

Katherine M. Masaki, D.D.S., M.S.
1150 S. King St., Ste. 1103
Honolulu, HI 96814

NOTICE OF PRIVACY PRACTICES

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.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about out privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect **September 1, 2013**, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at ay time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

We use and disclose your PHI for different purposes, including treatment, payment, and healthcare operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related, genetic, alcohol and/or substance abuse records and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment: We may disclose your PHI for your treatment. For example, we may disclose your PHI to a specialist providing treatment to you.
Payment: We may use and disclose your PHI to obtain payment for services we provide to you.
Healthcare Operations: We may use or disclose your PHI in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.
Persons Involved In Care: We may use or disclose PHI to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, or your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
Required by Law: We may use or disclose your PHI when we are required to do so by law.
Abuse or Neglect: We may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.
Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.
Health Oversight Activities: We may disclose your PHI to an oversight agency for activities authorized by law. These include audits, investigations, inspections and credentialing, as necessary for licensure and for the government to monitor the healthcare system, government programs and compliance with civil rights laws.
Coroners, Medical Examiners, Funeral Directors: We may release your PHI to a coroner or medical examiner for identification purposes, determining cause of death or to perform other duties authorized by law.
Worker's Compensation: Your PHI may be disclosed by us as authorized to comply with workers' compensation laws and other similar programs established by law.

Business Associates: Some services are proved through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so they can perform the identified services. We require the business associate(s) to appropriately safeguard your PHI. Examples of business associates include billing services and dental laboratories.

Appointment Reminders: We may use or disclose your PHI to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

The following uses and disclosures of PHI require your written authorization:

- Marketing and fundraising
- Disclosure of for any purposes which require the sale of your information

YOUR PROTECTED HEALTH INFORMATION (PHI) PRIVACY RIGHTS:

Access: You have the right to look at or get copies of your PHI, with limited exceptions. You must make a request in writing to obtain access to your PHI. You may obtain a form to request access by using the contact information listed at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request copies, we will charge you $0.50 for each page, $8.00 per hour for staff time to copy your PHI, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclose your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003.

If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Right to Request a Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment of health care operations and the information pertains solely to a healthcare item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication: You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment: You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation.

Right to Notification of a Breach: You will receive notifications of breaches of your unsecured PHI as required by law.

Electronic Notice: You are entitled to receive this Notice in written form or by electronic mail (e-mail) upon request.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we have violated your rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the en of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with us or with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Katherine M. Masaki, D.D.S., M.S.
Ph: 808-596-4840

I have read, understand and agree to the "Notice of Privacy Practices" of Katherine M. Masaki, D.D.S., M.S.

Signature of Patient / Parent / Guardian: _____

For (patient): _____ Date: _____

Katherine M. Masaki, D.D.S., M.S.
Orthodontist

Eleven50 Building
1150 S. King St. Suite 1103
Honolulu, HI 96814

808.596.4840
alohaortho123@gmail.com
www.alohaorthodontics.org

Office Policy Form

*** Please read the following and sign below.**

I am the person responsible for the account.
I agree to pay the costs of orthodontic care as described by the fee schedule, which I have a copy of. Payments are due on the first of the month. You can pay them with no added fee if they are received or post dated by the end of the month. There will be a 20 dollar fee per month for any past due balance (any balance over 30 days past due.) There is a bounced check fee of $40.

Please make check out to: "Katherine M. Masaki, D.D.S., M.S."
Mail your payment to:
Katherine M. Masaki, D.D.S., M.S.
Eleven50 Building
1150 S. King St., Suite 1103
Honolulu, HI 96814
Or you can bring your payment to the office at the time of your appointment.

I give authorization to file my insurance as needed. If expected insurance does not come in, the person responsible for the account will need to pay that amount. Make sure not to terminate your orthodontic insurance coverage until you verify with your insurance company that all benefits have been received. (Sometimes it takes about 2 years.)

For missed appointments or appointments rescheduled without 24 hours notice, there will be a 45 dollar fee.

Some X-rays are not included in the fee, but might be covered by your dental insurance.

If oral hygiene is not adequate or if the patient is not compliant with treatment instructions the braces may be removed early, and/or orthodontic treatment terminated.

Everyone needs to wear retainers after treatment to ensure that teeth stay in place.

There is a replacement fee for lost orthodontic appliances.

I have read the "Informed Consent for the Orthodontic Patient: Risks and Limitations of Orthodontic Treatment" form. I have read and agree to the "Notice of Privacy Practices," of Katherine M. Masaki D.D.S., M.S., which explains how my health and records can be used and disclosed and how I can get access to the information. I understand the content of the forms and have signed them in acknowledgement.

*** If you have read, understand and agree to all of the above, please print and sign your name below.**

Name (Print): _____ Date: _____

Name (Signature): _____

INFORMED CONSENT

for the Orthodontic Patient

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.

AAO American Association of Orthodontists®

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.

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.

Continued on next page

Patient or Parent/Guardian Initials _____

Patient _____ 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 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.

Patient or Parent/Guardian Initials _____

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 Date

Signature of Orthodontist/Group Name Date

Witness Date

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.

TRANSFERRING PATIENT

Orthodontic treatments vary widely. Transfer will likely increase treatment fees, may involve changes in payment policies, and may change your treatment and/or appliances. When you transfer to a new orthodontist, your treatment time is often extended by the process of transfer.

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

Witness Date

I have the legal authority to sign this on behalf of

Name of Patient

Relationship to Patient

Notes

PATIENT'S COPY