WALKER ORTHODONTICS, PC

Specialists In Advanced Airway Orthodontics For Children & Adults

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American Academy of Dental Sleep Medicine

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Congratulations! You have taken the first step to giving your child a winning smile and a healthier life. As a parent I know you want to give your child every possible opportunity to be happy and successful. At Walker Orthodontics we are honored you have chosen us to be part of your team in achieving that goal.

Studies have shown over and over that kids with a great straight smile are more confident, self-assured, higher achievers and are treated better by their peer groups, teachers, and employers. In this world of social media and selfies it can be a cruel place for a kid that has crooked teeth and walks around with their mouth open, all day, so they can breathe. It isn't fair, but it is a proven fact.

A straight, clean healthy smile can not only give your child the confidence they need to embrace their true worth but can pave the way toward easier socialization at school, church, or during extracurricular activities.

What sets us apart from other is...First we address "WHY" someone has crooked teeth, not just how to straighten them. Crooked teeth are typically a sign of a much bigger health problem and we are the experts in recognizing and treating such problems. So, your child not only gets straight teeth that are more stable, but they get the bonus of a healthier and happier life. They look better, sleep better and perform better for the rest of their lives.

Second, we realize that this is challenging time of life for your child and we have trained our team to be aware of children's feelings and fears. We strive to offer a service such that when your child leaves our office they feel better about themselves then when they walked through our door. We want you and your child to have a great experience and we guarantee your satisfaction.

Third, you as a parent are a part of our team and part of the plan for your child. No two kids are the same, so we need your input as to what is best for your child...*we listen.* There is no one "ideal" plan everyone but there is an ideal plan for your individual child and...*we listen.* For successful orthodontic treatment, your child needs the support of all of us and that includes the people who believe in them the most...their family.

Fourth, you *CAN* afford to have the best orthodontic care for your child. Today for the same cost of a Starbucks coffee every day of the year or a cell phone plan for a family of four you can give your child the look and confidence of a winner, for life. There is no other place you can get a better return on your investment. One of your financial experts will sit with you and figure out how to make this possible. We have some very exciting financing options and we are committed to your success.

So, let's get going on the road to success! Thanks again for your confidence and trust in me and my team. It is the beginning of a great experience, I guarantee it!

Patient Health Questionnaire

PATIENT INFORMATION

Date of completion

TMNDX™

☐Mr. ☐Ms. ☐Miss ☐Mrs. ☐Dr.

Name: _____
First Middle Initial Last

Age: _____ Date of Birth: _____

Referred by: _____ ☐DDS ☐MD ☐ENT ☐DC ☐Other

Location and/or Phone Number of Healthcare Provider: _____

Patient Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Alternate Contact Number: _____

Type of Employment: _____

Responsible Party (if different than Patient): _____

Address: _____ City: _____ State: _____ Zip: _____

Family Dentist: _____ Address and/or Phone: _____

Family Physician: _____ Address and/or Phone: _____

Reason(s) for this appointment: ☐Pain ☐Sleep/Airway ☐Orthodontics ☐Unknown

WHAT IS THE CHIEF COMPLAINT FOR WHICH YOU ARE SEEKING TREATMENT IN OUR OFFICE?

NOTE-PLEASE IDENTIFY YOUR CHIEF COMPLAINT AS #1, LIST ALL OTHER SYMPTOMS IN PRIORITY #2-9.

	Recent	Chronic (6 mo.+)
___ Headache pain	☐	☐
___ Ear pain	☐	☐
___ Jaw pain	☐	☐
___ Pain when chewing	☐	☐
___ Facial pain	☐	☐
___ Eye pain	☐	☐
___ Throat pain	☐	☐
___ Neck pain	☐	☐
___ Shoulder pain	☐	☐
___ Back pain	☐	☐
___ Limited ability to open mouth	☐	☐
___ Jaw joint locking	☐	☐
___ Jaw joint noises	☐	☐
___ Ear congestion	☐	☐
___ Sinus congestion	☐	☐
___ Dizziness	☐	☐
___ Tinnitus (ringing in the ears)	☐	☐
___ Muscle twitching	☐	☐
___ Vision problems	☐	☐
___ Other: _____	☐	☐

	Recent	Chronic (6 mo.+)
___ Kicking or jerking leg repeatedly	☐	☐
___ Swelling in ankles or feet	☐	☐
___ Morning Hoarseness	☐	☐
___ Dry mouth upon waking	☐	☐
___ Fatigue	☐	☐
___ Difficulty falling asleep	☐	☐
___ Tossing and turning frequently	☐	☐
___ Repeated awakening	☐	☐
___ Feeling unrefreshed in the morning	☐	☐
___ Significant daytime drowsiness	☐	☐
___ Frequent heavy snoring	☐	☐
___ Affects sleep of others	☐	☐
___ Gasping when waking	☐	☐
___ Told that "I stop breathing" during sleep	☐	☐
___ Night-time choking spells	☐	☐
___ Unable to tolerate C-Pap	☐	☐
___ Tooth grinding	☐	☐
___ Teeth crowding	☐	☐

Do you have concerns in any of these areas: ☐ General Appearance ☐ Ability to Function ☐ Overbite ☐ Smile

Other Comments: _____

Do any of the above complaints or concerns affect your daily life? _____

WHAT ARE THE RESULTS YOU ARE SEEKING FROM TREATMENT?

Patient Signature: _____ Date: _____

ALLERGIC REACTIONS

Please check any and all medications or substances that have caused an allergic reaction

☐ Anesthetics	☐ Codeine	☐ Penicillin
☐ Antibiotics	☐ Iodine	☐ Plastic
☐ Aspirin	☐ Latex	☐ Sedatives
☐ Barbituates	☐ Metals	☐ Sulfa

Other: _____

CURRENT MEDICATIONS

Please list all medications you are taking and the reason you take them. Include all over-the-counter medications, vitamins, herbs, etc.

Medication	Dosage	Reason for Taking

☐ See attached list

PREVIOUS TREATMENTS/MEDICATIONS FOR THE CONDITION WE ARE EVALUATING

Treatment and/or Medication	Doctor/Provider Name	Approximate Date of Treatment

I release and give my permission for this office to request information and communicate with the providers listed above.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if patient is a minor): _____ Date: _____

HEALTH AND MEDICAL HISTORY

☐Yes ☐No Are you currently pregnant?

☐Yes ☐No Have you sustained injury to: ☐Head ☐Neck ☐Face ☐Teeth ☐Other: _____

☐Yes ☐No Do you drink 4 or more cups of coffee per day?

☐Yes ☐No Have you had prior orthodontic treatments?

☐Yes ☐No Trouble breathing through nose

☐Yes ☐No Do you smoke tobacco?

☐Yes ☐No Consume alcohol or take sedatives

Patient Signature: _____ **Date:** _____

HEALTH AND MEDICAL HISTORY (CONTINUED)

Do you have, or have you experienced any of the following:

- ☐ Yes ☐ No Heart Disorder/ Heart Attack
- ☐ Yes ☐ No Heart Murmur
- ☐ Yes ☐ No Mitral Valve prolaps
- ☐ Yes ☐ No Heart Pacemaker
- ☐ Yes ☐ No Heart Palpitations
- ☐ Yes ☐ No Heart Valve Replacement
- ☐ Yes ☐ No Irregular Heartbeat
- ☐ Yes ☐ No Blood Pressure ☐ High ☐ Low
- ☐ Yes ☐ No Stroke
- ☐ Yes ☐ No Bleeding Easily
- ☐ Yes ☐ No Bruising Easily
- ☐ Yes ☐ No Cancer of _____
  Chemo ☐ Radiation ☐
- ☐ Yes ☐ No Anemia
- ☐ Yes ☐ No Asthma
- ☐ Yes ☐ No Birth Defects
- ☐ Yes ☐ No Diabetes
- ☐ Yes ☐ No Epilepsy
- ☐ Yes ☐ No Emphysema
- ☐ Yes ☐ No Glaucoma
- ☐ Yes ☐ No Gastroesophpgeal Reflex (Gerd)
- ☐ Yes ☐ No Hemophilia
- ☐ Yes ☐ No Hepatitis
- ☐ Yes ☐ No History of Substance Abuse
- ☐ Yes ☐ No Hypoglycemia
- ☐ Yes ☐ No Huntington's Disease
- ☐ Yes ☐ No Kidney Disease
- ☐ Yes ☐ No Liver Disease
- ☐ Yes ☐ No Leukemia
- ☐ Yes ☐ No Migraines
- ☐ Yes ☐ No Meniere's Disease
- ☐ Yes ☐ No Multiple Sclerosis
- ☐ Yes ☐ No Muscular Dystrophy
- ☐ Yes ☐ No Neuralgia
- ☐ Yes ☐ No Osteoarthritis
- ☐ Yes ☐ No Osteoporosis
- ☐ Yes ☐ No Ovarian Cyst
- ☐ Yes ☐ No Parkinson's Disease
- ☐ Yes ☐ No Rheumatic Fever
- ☐ Yes ☐ No Rheumatoid Arthritis
- ☐ Yes ☐ No Scarlet Fever

- ☐ Yes ☐ No Thyroid Problem
- ☐ Yes ☐ No Tuberculosis
- ☐ Yes ☐ No Intestinal Disorder
- ☐ Yes ☐ No Nervous System Disorder
- ☐ Yes ☐ No Anxiety
- ☐ Yes ☐ No Skin Disorder
- ☐ Yes ☐ No Urinary Tract Disorder
- ☐ Yes ☐ No Chronic Fatigue
- ☐ Yes ☐ No Fibromyalgia
- ☐ Yes ☐ No Cold hands and feet
- ☐ Yes ☐ No Depression
- ☐ Yes ☐ No Difficulty concentrating
- ☐ Yes ☐ No Difficulty breathing at night for sleep
- ☐ Yes ☐ No Dizziness
- ☐ Yes ☐ No Excessive Thirst
- ☐ Yes ☐ No Fainting
- ☐ Yes ☐ No Fluid Retention
- ☐ Yes ☐ No Frequent colds/flu
- ☐ Yes ☐ No Frequent cough
- ☐ Yes ☐ No Frequent ear infections
- ☐ Yes ☐ No Frequent sore throat
- ☐ Yes ☐ No Frequent awaking at night - number of times _____
- ☐ Yes ☐ No Hearing impairment
- ☐ Yes ☐ No Memory Loss
- ☐ Yes ☐ No Hay Fever
- ☐ Yes ☐ No Insomnia
- ☐ Yes ☐ No Muscle aches
- ☐ Yes ☐ No Muscle fatigue
- ☐ Yes ☐ No Muscle spasms
- ☐ Yes ☐ No Muscle tremors
- ☐ Yes ☐ No Poor circulation
- ☐ Yes ☐ No Psychiatric Care
- ☐ Yes ☐ No Recent weight gain
- ☐ Yes ☐ No Recent weight loss
- ☐ Yes ☐ No Sinus problems
- ☐ Yes ☐ No Shortness of breath
- ☐ Yes ☐ No Slow healing sores
- ☐ Yes ☐ No Speech difficulties
- ☐ Yes ☐ No Swollen, stiff or painful joints
- ☐ Yes ☐ No Tired muscles

Additional Information _____

_____

SURGICAL HISTORY *Have you had any of the following:*

- ☐ Yes ☐ No General Anesthesia
- ☐ Yes ☐ No Adenoids removed
- ☐ Yes ☐ No Tonsils removed
- ☐ Yes ☐ No Jaw Joint Surgery
- ☐ Yes ☐ No Orthognathic Surgery
- ☐ Yes ☐ No Oral Surgery

Removal of third molar (wisdom teeth) ☐ Other ☐

- ☐ Yes ☐ No Other surgery _____ *please list below*

Other types of surgery _____

_____

_____

_____

Patient Signature: _____ Date: _____

CURRENT SYMPTOMS

Head Pain

Location (*L=Left R=Right B=Bilateral*)	*Recent*	*Chronic* (*over 6 mo.*)	*Severity* *Mild* *Mod* *Severe*	*Duration* *Min.* *Hrs.* *Days*	*Frequency* *Occasional* *Frequent* *Constant*
L R B Frontal (Forehead)	☐	☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐
L R B Generalized	☐	☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐
L R B Parietal (Top of head)	☐	☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐
L R B Occipital (Back of head)	☐	☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐
L R B Temporal (Temple area)	☐	☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐

Do you have pain or discomfort in any of the following areas? If so, please indicate the approximate date the pain began.

Jaw Pain

☐ L ☐ R Jaw pain with opening
☐ L ☐ R Jaw pain when chewing
☐ L ☐ R Jaw pain at rest

Jaw Joint Sounds

☐ L ☐ R Jaw sounds with opening
☐ L ☐ R Jaw sounds when chewing
☐ L ☐ R Jaw sounds at rest

Jaw Locking

☐ Yes ☐ No Jaw locks closed
☐ Yes ☐ No Jaw locks open

Jaw Joint Symptoms

☐ Yes ☐ No Teeth clenching ☐ Day ☐ Night
☐ Yes ☐ No Teeth grinding ☐ Day ☐ Night

Eye Related Conditions

☐ Yes ☐ No Blurred vision
☐ Yes ☐ No Double vision
☐ Yes ☐ No Eye pain

☐ Yes ☐ No Pain or pressure behind the eyes
☐ Yes ☐ No Extreme sensitivity to light (photophobia)
☐ Yes ☐ No Wear of glasses or contact lenses

Ear Related Conditions

☐ L ☐ R Buzzing in the ears
☐ L ☐ R Ear congestion
☐ L ☐ R Ear pain
☐ L ☐ R Hearing loss
☐ L ☐ R Itchiness or Stuffiness in ears

☐ L ☐ R Pain behind the ear
☐ L ☐ R Pain in front of the ear
☐ L ☐ R Recurrent ear infections
☐ L ☐ R Ringing in the ear (Tinnitus)

Throat Related Conditions

☐ Yes ☐ No Chronic sore throat
☐ Yes ☐ No Difficulty swallowing
☐ Yes ☐ No Swollen glands

☐ Yes ☐ No Thyroid enlargement
☐ Yes ☐ No Tightness in throat
☐ Yes ☐ No Constant feeling of a foreign object in throat

Neck Related Conditions

☐ Yes ☐ No Limited movement of neck
☐ Yes ☐ No Neck pain

☐ Yes ☐ No Numbness in hands or fingers
☐ Yes ☐ No Swelling in the neck

Patient Signature: _____ Date: _____

Shoulder Related Conditions

☐Yes ☐No Shoulder pain
☐Yes ☐No Shoulder stiffness
☐Yes ☐No Tingling in hands or fingers

Back Related Conditions

☐Yes ☐No Back pain - lower
☐Yes ☐No Back pain - middle
☐Yes ☐No Back pain - upper
☐Yes ☐No Sciatica
☐Yes ☐No Scoliosis

Mouth and Nose Related Conditions

☐Yes ☐No Dry mouth
☐Yes ☐No Chronic sinusitis
☐Yes ☐No Frequent snoring
☐Yes ☐No Burning tongue
☐Yes ☐No Broken teeth
☐Yes ☐No Frequent biting of the cheek

Sleep Conditions

Please select Yes or No answers based on your average sleep experience and/or what a sleep partner has told you

Sleep Positions ☐Side ☐Back ☐Stomach ☐Varies
Is it easy to fall asleep? ☐Yes ☐No
Do you feel rested upon AM waking? ☐Yes ☐No
Stopped breathing during sleep? ☐Yes ☐No

Average hours of sleep per night? _____
Do you wake often during the night? ☐Yes ☐No
Gasping or Choking during sleep? ☐Yes ☐No
Have you ever had a Sleep Study (PSG)? ☐Yes ☐No
Result was _____

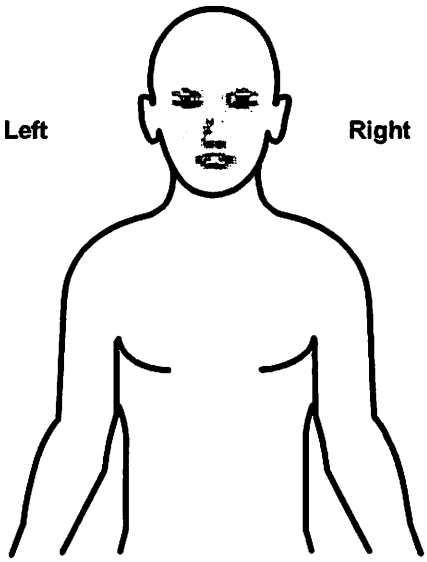
HISTORY OF SYMPTOMS

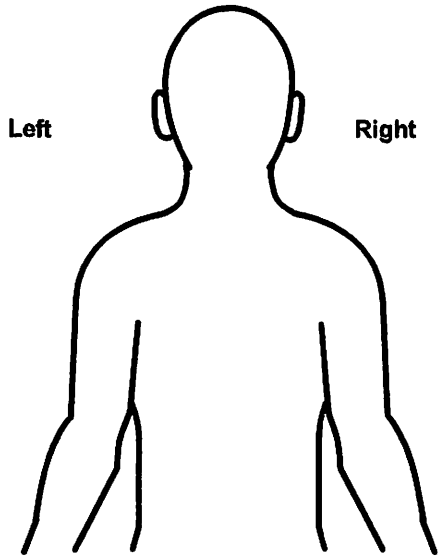
On what date, or approximate date, did this condition or symptoms first occur? _____
☐Yes ☐No **Does any family member have the same or similar problem? If yes, please explain.** _____
Can you relate your pain or condition to a motor vehicle accident or traumatic injury? _____
If yes, please complete Trauma History Section, enclosed as a separate form.

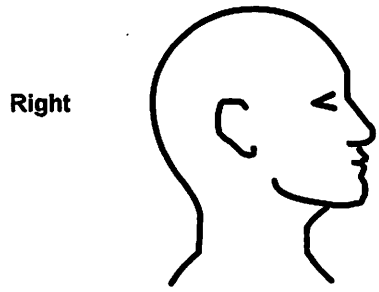
I authorize the release of all examination findings and diagnosis, report and treatment plans, etc., to any referring or treating health care provider. I additionally authorize the release of any medical information to insurance companies, or for legal documentation to process claims. I understand that I am responsible for all charges incurred for my treatment regardless of insurance coverage.

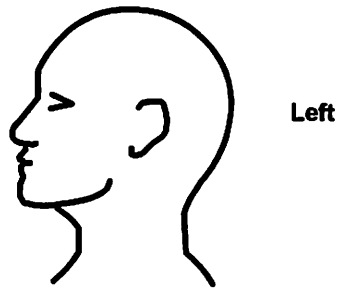
Patient Signature: _____ Date: _____

Parent/Guardian Signature (if patient is a minor): _____ Date: _____









Indicate Areas of Pain
Following the Pain Scale:
1 Mild pain
2 Moderate pain
3 Severe pain

AUTHORIZATION TO RELEASE INFORMATION TO THE BELOW LISTED REFERRING AND TREATING HEALTH CARE PROFESSIONALS:

Doctors Name **Location/Phone**

_____

_____

_____

_____

_____

_____

_____

I authorize the release of communications regarding my treatment with _____ including a full report of examination findings, diagnosis, treatment plan, and progress reports to the providers listed above.

Signed _____ Date _____

Daytime Sleepiness Evaluation

Epworth Sleepiness Scale

The Epworth Sleepiness Scale was developed and validated by Dr. Murray Johns of Melbourne Australia. It is a simple, self-administered questionnaire –widely used by sleep professionals in quantifying the level of daytime sleepiness.

For the following situations, answer with one of the following numbers:

0 - Would never doze

1 - slight chance of dozing

2 - moderate chance of dozing

3 - high chance of dozing

Situation	**Score**
Sitting and reading	
Watching Television	
Sitting, inactive in a public place	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total Score	

Nighttime Sleepiness Evaluation

Screening Tool for Sleep Apnea

Developed by David White, M.D., Harvard Medical School, Boston, MA

Please answer the following questions.

1.Snoring

a) Do you snore on most night (> 3 nights per week)?

Yes (2) No (0) _____

b) Is your snoring loud? Can it be heard through a door or wall?

Yes (2) No (0) _____

2. Has it ever been reported to you that you stop breathing or gasp during sleep?

Never (0) Occasionally (3) Frequently (5) _____

3. What is your collar size?

Male: Less than 17 inches (0) more than 17 inches (5) _____

Female: Less than 16 inches (0) more than 16 inches (5) _____

4. Do you occasionally fall asleep during the day when:

a) You are busy or active?

Yes (2) No (0) _____

b) You are driving or stopped at a light?

Yes (2) No (0) _____

5. Have you had or are you being treated for high blood pressure?

Yes (1) No (0) _____

TOTAL _____

Score

9 points or more	**6-8 points**	**5 points or less**
Refer to sleep specialist or order sleep study	Gray area, use clinical judgment	Low probability of sleep apnea

Walker Orthodontics, P.C

John H. Walker, D.M.D.
Martha M. Neely, D.M.D., M.S.D.

Informed Consent for the Orthodontic Patient

As a rule, excellent orthodontic results can be achieved with informed and cooperative patients. Thus, the following information is routinely supplied to anyone considering orthodontic treatment in our office. While recognizing the benefits of a pleasing smile and healthy teeth, you should also be aware that orthodontic treatment, like any treatment of the body, has some inherent risks and limitations. These are seldom enough to contraindicate treatment, but should be considered in making the decision to wear orthodontic appliances. Please feel free to ask any questions about this.

Orthodontic treatment usually proceeds as planned and we do 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. Much of the success of treatment depends on patient cooperation in keeping appointments, maintaining good oral hygiene, avoiding loose or broken appliances, and following the doctor's instructions carefully.

The total time for treatment can be delayed beyond our estimate. Lack of skeletal growth, poor elastic wear and poor headgear cooperation are all-important factors, which could lengthen treatment time as well as the quality of the result.

The mouth is very sensitive to changes and the introduction of orthodontic appliances means that you must expect a period of adjustment. There may be occasional discomfort associated with orthodontic treatment. The period of tenderness or sensitivity varies with each patient. This can usually be resolved by using a simple over-the-counter pain medication.

Teeth have a tendency to rebound to their original position after orthodontic treatment. This is called relapse. Very severe problems have a higher tendency to relapse and the most common area for relapse is the lower front teeth. After band removal, a positioner or retainers are placed to minimize relapse. Full cooperation in wearing these appliances is vital. We will make our correction to the highest standards and in many cases overcorrect in order to accommodate the rebound tendencies. When retention is discontinued, some relapse is still possible.

Some cases will require the removal of deciduous (baby) teeth or permanent teeth. There are additional risks associated with removal of teeth, which you should discuss with your family dentist or oral surgeon prior to the procedure.

Sometimes orthognathic surgery is necessary in conjunction with orthodontic treatment, especially to correct crowding or severe jaw imbalances. Risks involved with treatment and anesthesia should be discussed with your oral surgeon before making your decision to proceed with this procedure.

Decalcification (permanent markings), decay, or gum disease can occur if patients do not brush their teeth properly and thoroughly during the treatment period. Excellent oral hygiene and plaque removal is imperative. Sugars and between meal snacks should be eliminated. The patient must maintain regular check-ups with their dentist.

In some cases, the root ends of the teeth are shortened during treatment. This is called root resorption. Under healthy circumstances the shortened roots are no disadvantage. However, in the event of gum disease in later life, the root resorption can reduce the longevity of the affected teeth. It should be noted that not all root resorption arises from orthodontic treatment. Trauma, cuts, impaction, endocrine disorders and idiopathic reasons can also cause root resorption.

A non-vital or dead tooth is a possibility. A tooth that has been traumatized from a deep filling or even a minor blow can die over a long period of time with or without orthodontic treatment. An undetected non-vital tooth may flare up during orthodontic movement, requiring endodontic (root canal) treatment to maintain it.

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.

Sometimes orthodontic appliances may be accidentally swallowed or aspirated or may irritate or damage the oral tissues. The gums, cheeks and lips may be scratched or irritated by loose or broken appliances or by blows to the mouth.

Headgear instructions must be followed carefully. A headgear that is pulled outward while the elastic force is attached can snap back and poke into the face or eyes. Be sure to release the elastic force before removing the headgear from the teeth.

There is a risk that problems may occur in the temporomandibular joints (TMD). Although this is rare, it is a possibility. Tooth alignment or bite correction can improve tooth-related causes of TMJ pain but not in all cases. Tension appears to play a role in the frequency and severity of joint pains. If a prior temporomandibular joint problem exists or if there is no temporomandibular problem prior to orthodontics; it may develop at some time following treatment. Should a TMJ problem develop, it will be addressed as a separate problem at that time.

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.

Due to the wide variation in the size and shape of teeth, achievement of the most ideal result may require restorative dental treatment. The most common types of treatment are cosmetic bonding, crown and bridge restorative dental care and/or periodontal therapy.

I hereby give permission for the use of orthodontic records, including photographs and x-rays, made in the process of examinations, treatment, and retention for purposes of professional consultations, research, education, or publication in professional journals. Additionally, I waive the right to royalties or other compensation arising or related to the use of the orthodontic records.

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.

Please, let's make every effort to do it right. This takes cooperation from everyone – myself, my staff, your family and most of all the patient. Thank you for your cooperation in this matter

Sincerely, John H. Walker, D.M.D.
Martha M. Neely, D.M.D., M.S.D.

I have read and understand the above and consent to the treatment. Signature_____ Date_____

PATIENT PRIVACY POLICY NOTICE
WALKER ORTHODONTICS, P.C.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. The privacy of your health care is important to us, please read and review carefully.

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 our 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. The notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of the 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 any time. For more information about our privacy practices, or for additional copies of this notice contact us using the information listed at the end of this notice

Uses and Disclosures Of Your Health Information:
We may use and disclose health information about you for purposes of treatment, payment and health care operations.

Treatment: We may use and disclose protected health care information to your dentist, physician, or other health care provider giving you health care.

Payment: We may use and disclose health care information to obtain payment for services we provide for you. For example a third party payer (insurance) to coordinate benefits and receive payment for services rendered. We may also disclose you health information to another health care provider or entity that is subject to the federal Privacy Rules for its payments.

Healthcare Operations: Our office may use and disclose your health care information with our healthcare operations. This includes quality assessment and improvement of activities, reviewing the competence, qualifications, and performance of health care professionals. We may disclose your healthcare information to other healthcare professionals who have a relationship with you to support some of their health care operations. We may also use and disclose your health care information when conducting education and training programs for certification, credentialing and licensing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by our authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you as described in the Patients 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 the payment for your healthcare, but only if you agree that we may do so. If you are not present, or in the event of your incapacity or an emergency, we will disclose your health information based on our professional judgment of whether the disclosure would be in your best interest. We may 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 x-rays or other similar forms of health information. We may disclose or use information about you to notify or assist in notifying a person involved in your care of your location and general condition.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required By Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information 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 health information 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 authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstance.

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

PATIENT RIGHTS

Access: you have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. You may obtain access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we may—but are not required to--prepare a summary or an explanation of 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 disclosed 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 requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing and signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternate locations. You must make your request in writing. Your request must specify the alternate means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.
Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form

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 may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in a 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 end 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 the U.S. Department of Health and Human Services.

Contact Office: Walker Orthodontics
Telephone: (978) 345-7988 **FAX:** (978) 345-1191
E-mail: walkerortho@verizon.net
Address: 119 Massachusetts Avenue Lunenburg, MA 01462

I have received a copy of the Notice of Privacy Practice for Walker Orthodontics PC. You may refuse to sign this Acknowledgement.

Patient Name_____ Date_____

Signature (Patient/Guardian)_____

i-CAT® CBCT INFORMED CONSENT

The office of Walker Orthodontics now offers an exciting new technology for our patients and for patients of other doctors who might be referred here. This technology is i-CAT® Cone Beam Computer Assembled Tomography (CBCT) imaging, sometimes called 3-D radiographs or x-rays.

Using CBCT means that we now have the ability to take 3-D images of the teeth, jaws, bones and facial structures at lower costs and with much less energy than a typical CT scan used in hospitals.

3-D imaging provides improved diagnosis for our patients, especially in cases of impacted teeth, dental implants, surgical treatment, and even more complex cases. Understandably, you may have questions about exposure to these types of x-rays. For your comfort here are come facts you should know about 3-D imaging. The 8.5 second i-CAT® CBCT exposure is:

- About 1/2 as much as a full series of orthodontic digital images
- About 1/5 as much as a full mouth series of standard dental x-rays (28 films)
- About 1/70 as much as a typical medical CT scan

CBCT offers patients enhanced diagnostic value at significantly reduced exposure. CBCT scans can image the entire head and most of the neck. As orthodontists, we evaluate teeth, jaws and the surrounding bone using CBCT's for those limited purposes. Our training does not provide for evaluation and diagnosis outside those areas. Since CBCT imaging can cover a broader area, we want to offer you the opportunity to have your CBCT scan read by an oral radiologist who is trained to evaluate and diagnose possible pathology in these areas.

We can refer you to a radiology group for this purpose. The cost is $125.00. If you are interested in taking advantage of this service, please initial the applicable section and sign the acknowledgement below. _____

( ) Yes, I want to have my i-CAT® CBCT scans read by an oral radiologist. I understand that I am responsible for this additional cost.

( ) No. I understand the risks and benefits of having my CBCT read and interpreted by an oral radiologist. However, I am knowingly declining such a referral.

Print Patient Name_____

Patient/Guardian Signature_____

Date_____

Walker Orthodontics
119 Massachusetts Avenue
Lunenburg, MA 01462

Website and Social Medical Release Form

I the undersigned, do hereby grant permission to Walker Orthodontics to post my and or my child's story, photo, or other item hereinafter referred to as "materials" to our website (www.drwalkerortho.com), and facebook.

I hereby release you, your representatives, employees, managers, members, and officers, from all claims and demands arising out of or in connection with any use of said "Materials" including without limitation, all claims for invasion of privacy, infringement of my right of publicity, and any other personal and or property rights.

I acknowledge and agree that no sums whatsoever will be due to me as a results of the use of "Materials" or any rights therein.

Parent/ Guardian signature:_____ Date:_____

Printed name: _____

I acknowledge that my child is under 18 years old and lacks the legal capacity to enter into binding agreements. Accordingly, I have read this release and consent to my child's inclusion in the "Materials" will not contest the rights granted in this release, and shall assist and support you in any and all legal proceeding for affirmation of the agreement, should you choose to have a count of law affirm this agreement.

Childs Name:_____

Parent/ Legal Guardian_____ Date:_____

Walker Orthodontics
119 Massachusetts Avenue
Lunenburg, MA 01462
PH: (978) 345-7988
FAX: (978) 345-1911

Revision Date: May 18, 2017

Photography Release Waiver

Purpose: Walker Orthodontics is committed to providing high-quality healthcare to its patients. As such, the use of clinical photography is limited to the purposes of diagnosis, treatment, and professional education. This policy establishes guidelines for managing multimedia imaging of patients. For the purpose of this policy, multimedia imaging includes photography, videotaping, and audiotaping.

Policy: Clinical photography of patients may be appropriate for the diagnosis and treatment of medical conditions as well as professional education. Clinical photography can be accomplished through a variety of multimedia technology to collect, analyze, and store patient protected health information. Use of these medias will be carefully controlled and executed in compliance with all state and federal regulations as well as other organizational policies and procedures.

All photographs must be appropriately identified with patient name, medical record number, account number, and date of admission.

Any disclosure of clinical photography is considered the release of protected health information and must follow all applicable organizational policies.

Clinical photography does not include photography of patients for the purposes of promotion, artwork, or advertising of Walker Orthodontics photographs are addressed through the public relations or department and follow the policies and procedures within that department. A separate release will need to be signed.

Clinical photography is defined as any videotaping, filming, or still photography of patients and includes, but is not limited to:

1. Initial photos taken at exam
2. X-rays/ scans
3. Debonding photos

Clinical photography is not allowed by clinical care providers on their individually owned camcorders, digital cameras, or Polaroids.

Consent

The patient or responsible party ***must be informed prior to*** the photography of the use and purpose of the picture.

The patient or responsible party has ***the right to refuse.***

The patient or responsible party has ***the right to withdraw consent at any time*** by contacting the compliance officer.

Releasing Clinical Photographs

Once taken, clinical photographs become a permanent part of the legal health record and can be released as such according to state and federal regulations.

Clinical photographs must be identified as a separate page/section of the electronic health record (OR PAPER RECORD) with the appropriate patient-identifiable information including patient name, medical record number, account number, date of admission, and attending physician.

Requests for disclosures of clinical photography for the purposes of treatment, payment, or operations do not require patient consent.

Requests for external disclosures of clinical photography that are not for treatment, payment, or operations requires the patient's informed consent prior to the release. Examples or external disclosures requiring authorization include, but are not limited to:

- Requests by law enforcement
- Requests by social services

By signing this form below I confirm that this consent form has been explained to me in terms which I understand.

1.) I consent for these photographs to be used in the process of diagnosis, treatment, medical publications, and professional education.

_____Signature _____Witness _____Date

2.) I agree for my images to be shown for teaching purposes AND to be used for my medical records but NOT for medical publications.

_____Signature _____Witness _____Date

3.) I agree to use of my images of medical reasons ONLY

_____Signature _____Witness _____Date