Brodie L. Bowman, DMD
Specialist in Orthodontics & Dentofacial Orthopedics
CHILDREN + TEENS + ADULTS

Hi,

Thank you for selecting Brodie Bowman Orthodontics for your orthodontic treatment needs!

Your visit will involve a comprehensive orthodontic examination, including any necessary orthodontic records. If treatment is recommended, we will have plenty of time to discuss the treatment plan, the estimated treatment time, and the fees associated with this service.

If you have insurance that covers orthodontic treatment, please make sure we have that information before the day of your examination so we can give you an estimated benefit during the appointment.

We have included some important forms with this letter. Please complete them ahead of time and Email to info@bowmandmd.com or Fax to 850-863-5812. Or you can bring them with you to your appointment.

We are looking forward to a relaxed and pleasant visit with you. Please call us or visit our website at www.bowmandmd.com for directions or for more information about our practice. We will see you soon.

Sincerely yours,

The Team at Brodie Bowman Orthodontics

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PATIENT INFORMATION - ADULT

Date _____

Title _____ Legal Name _____ Social Security # _____

Preferred Name _____ DOB _____ Age _____ Gender _____

E-Mail Address _____ Occupation _____

Address _____

Phone 1 _____ Phone 2 _____

Employer _____ Marital Status _____

Spouse's Name _____

Referred By _____ Hobbies/Interests _____

Past or Present Family Members in Treatment _____

Have you Consulted an Orthodontist Before? _____

Why are you seeking orthodontic treatment? _____

PRIMARY INSURANCE INFORMATION

Subscriber's Name _____ DOB _____

Address _____ Phone _____

Employer _____

Insurance Company _____ Phone _____

Group Number _____ Subscriber ID/SS# _____

SECONDARY INSURANCE INFORMATION

Subscriber's Name _____ DOB _____

Address _____ Phone _____

Employer _____

Insurance Company _____ Phone _____

Group Number _____ Subscriber ID/SS# _____

Signature _____ Date _____

(Parent / Legal Guardian)

MEDICAL HISTORY

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Patient's Name _____ Date _____
Dentist's Name _____ Date of Last Dental Exam _____
Physician's Name _____ Date of Last Physical Exam _____

Allergies or reactions to any of the following:

Y __ N __ Aspirin, Ibuprofen or Tylenol
Y __ N __ Barbiturates
Y __ N __ Codeine or other narcotics
Y __ N __ Latex
Y __ N __ Local anesthetics
Y __ N __ Metals
Y __ N __ Penicillin or other antibiotic
Y __ N __ Plastic or vinyl
Y __ N __ Sedatives
Y __ N __ Sleeping pills
Y __ N __ Sulfa drugs
Y __ N __ Other_____

Medications:

Please list medications, nutrient supplements, herbal medications & non-prescription medicines currently being taken:

Medication	Taken For

Now or in the past , has the patient had:

Y__N__ Adenoids or tonsils removed
Y__N__ Arteriosclerosis (hardening of the arteries)
Y__N__ Asthma, hay fever, sinus trouble or hives
Y__N__ Autoimmune disorders or immune system problems
Y__N__ Bleeding or bruising easily
Y__N__ High or low blood pressure - please circle
Y__N__ Cancer, tumor, chemotherapy or radiation treatment
Y__N__ Chronic fatigue
Y__N__ Current pregnancy
Y__N__ Depression or other mental health disturbance
Y__N__ Diabetes
Y__N__ Dizziness
Y__N__ Epilepsy or other seizure disorder
Y__N__ Fibromyalgia
Y__N__ General anesthesia
Y__N__ Hearing impairment
Y__N__ Heart problems (murmur, irregular heartbeat, valve defect or replacement, pacemaker, palpitations)
Y__N__ Frequent coughs, colds, or sore throats
Y__N__ Hemophilia
Y__N__ Hepatitis, AIDS, or HIV positive
Y__N__ Injury to face, neck, mouth or teeth - please circle
Y__N__ Insomnia
Y__N__ Jaw joint surgery
Y__N__ Kidney or liver problems
Y__N__ Meniere's disease
Y__N__ Multiple sclerosis
Y__N__ Muscular dystrophy
Y__N__ Nighttime breathing problems (snoring or sleep apnea)
Y__N__ Nervousness
Y__N__ Neuralgia
Y__N__ Osteoarthritis (stiff or swollen joints)
Y__N__ Osteoporosis
Y__N__ Parkinson's disease
Y__N__ Prior orthodontic treatment
Y__N__ Psychiatric care
Y__N__ Rheumatic fever
Y__N__ Rheumatoid arthritis
Y__N__ Scarlet fever
Y__N__ Skin disorder
Y__N__ Speech difficulties
Y__N__ Stroke or heart attack
Y__N__ Tuberculosis
Y__N__ Wisdom teeth extraction
Y__N__ Birth defects or hereditary problems
Y__N__ Endocrine or thyroid problems
Y__N__ Stomach ulcer or hyperacidity
Y__N__ Polio, mononucleosis or pneumonia
Y__N__ Vision problems
Y__N__ Loss of weight recently, poor appetite
Y__N__ Eating disorder (anorexia or bulimia)
Y__N__ Chest pain, shortness of breath or swelling ankles
Y__N__ Frequent or severe headaches
Y__N__ Other condition

Emergency Contact _____ Relationship_____ Phone # _____

Patient / Parent Signature _____ Today's Date _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Patient's Legal Name: _____

Section B: To the Patient – Please Read these Statements Carefully

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available upon request with this Consent. We encourage you to read it carefully and completely before signing this consent.

Office Procedures: As a part of the practice procedures our doctors reserve the right to use patient photographs, x-rays, videos and other photographic reproductions for the purpose of professional academic education and practice promotion, including use on website, brochures and social media sites.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will make available upon request a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revision of our Notice, at any time by contacting:

Contact Person	Traci Havens
Telephone	850-659-7599
Email	info@bowmandmd.com
Address	28 Racetrack Rd, Fort Walton Beach, FL 32547

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice or your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Section C: Signature

Patient/Parent Signature _____ Today's Date _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

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POTENTIAL RISKS AND LIMITATIONS OF ORTHODONTIC TREATMENT

To our patients:

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 at the pre-treatment consultation or prior to placement of orthodontic appliances.

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 a must. Sugars and between meal snacks should be eliminated.

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 appliance removal, retainers are place to minimize relapse. Full cooperation in wearing the retainer 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.

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.

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 could reduce the longevity of affected teeth. It should be noted that not all root resorption arises from orthodontic treatment. Trauma, cuts, impaction, endocrine disorders, or idiopathic reasons can also cause root resorption.

There is also a risk that problems may occur in the temporomandibular joints (TMJ). 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.

Occasionally, a person who has grown normally and in average proportions may not continue to do so. If growth becomes disproportionate, the jaw relation can be affected and original treatment objectives may have to be compromised. Skeletal growth disharmony is a biological process beyond the orthodontist's control.

The total time for treatment can be delayed beyond our estimate. Lack of facial growth, poor elastic wear or headgear cooperation, broken appliances and missed appointments are all important factors which could lengthen treatment time and affect the quality of the result.

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.

So, please, let's make every effort to do it right. This takes cooperation from everyone - myself, my team, your family, and most of all, the patient. I am thanking you in advance for your cooperation in this matter.

Diagnostic Records taken for treatment may be used for the purposes of professional consultations, research, education or publication in journals. In addition, with your permission patient names and photos may be displayed in our office, published in our newsletters, or on our website / social media outlets.

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

Signature _____ Date _____

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AUTHORIZATION TO RELEASE PATIENT RECORD INFORMATION

I hereby authorize Dr Brodie L. Bowman to disclose facial and/or dental photographs of the following patient as approved below:

Patient Name:_____
Patient Date of Birth:_____

Please check the appropriate answer to each of the following questions:

1.) May the patient's picture be displayed on the office website, social media outlets and/or within the office for the purpose of informing patients of the positive outcome we have achieved?

☐ Yes ☐ No

2.) May the patient's picture be displayed of the office website, social media outlets and/or within the office if they are a contest prize winner?

☐ Yes ☐ No

3.) May the patient's records including photographs be used for the purposes of professional consultations, research, education or publication in professional journals?

☐ Yes ☐ No

Please Note:

Financial Disclosure: I understand that the practice of Dr Brodie L. Bowman is not receiving compensation from anyone for the use of the patient's photo.

Refusal to sign: I understand that refusal to sign part or all of this Authorization will in no way affect the patient's treatment.

Revocation: I understand that I may revoke this authorization at any time by sending a written notice to the practice. All photos will be removed promptly once the revocation is received.

Certification: I certify that I am the patient.

Signature _____ Date _____

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AUTHORIZATION TO RELEASE / DISCUSS INFORMATION

I, _____, being of legal age, give Dr. Brodie L. Bowman authorization to release and discuss health, dental, and financial information regarding _____with the person / persons listed below:

Name: _____ Relationship to patient: _____

Home#:_____ Mobile#: _____Work#: _____

Name: _____ Relationship to patient: _____

Home#:_____ Mobile#: _____Work#:_____

Name: _____ Relationship to patient: _____

Home#:_____ Mobile#: _____Work#: _____

This authorization will stay in effect unless I request that it be changed.

Print Name: _____

Signature _____ Date _____