

**Dr. Nicholas S. Ising DMD, MS, PLLC
ORTHODONTIST**

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: To be completed by Legal guardian (if patient is under 18 years old)

Patient's Name: _____

Patient's Address: _____

Telephone: _____ Email: _____

Patient Social Security Number: _____

Section B: TO THE PATIENT or Legal guardian – PLEASE READ THE FOLLOWING 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 use 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 accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

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 issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain.

270-769-2186 (office) 270-982-2666 (fax)

E-mail: smileteam@bbtel.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of 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 the 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.

Signature: _____

Date: _____

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Orthodontist

A legal requirement facing all practitioners of medicine and dentistry is that the patient, or legal representative of the patient, gives the practitioner informed consent. Informed consent indicates your awareness of the negatives as well as the positive aspects of orthodontic treatment.

While recognizing the benefits of a pleasing smile and healthy teeth, you should also be aware that orthodontic treatment has some inherent risks and limitations. These are seldom enough to contraindicate treatment, but should be considered in making the decision to undergo orthodontic treatment. Most of these problem areas are explained below, but other unexpected problems may also occur.

Tooth decay, gum disease, and permanent markings (decalcifications), on the teeth can occur if orthodontic patients eat foods containing excessive sugar and/or do not brush their teeth properly and thoroughly. These same problems can occur without orthodontic treatment, but the risk is greater to an individual wearing braces. It is important that the patient see their dentist every six months during active treatment.

Shifting of the teeth can occur throughout life whether or not orthodontic treatment has been performed. There is the possibility that some crowding, rotations, or spacing may occur after treatment and retention. Persistent habits may contribute to such shifting.

The nerve of the tooth may become non-vital due to tooth trauma from a blow to the tooth, a deep filling, or pressure of the orthodontic appliances. Endodontic (root canal) treatment will be necessary to maintain a non-vital tooth.

In some cases the root ends of the teeth are shortened during orthodontic treatment. This is called root resorption. The shortened roots are usually no problem, but if gum disease occurs later in life, it could reduce the longevity of the teeth with excessive resorption. Root resorption can occur in individuals who have never had orthodontic treatment.

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

Occasionally problems may occur in the jaw joints, i.e., temporomandibular joints (TMJ) causing joint pain, headaches or ear problems. These problems can occur with or without orthodontic treatment. Any of the above noted symptoms should be promptly reported to the orthodontist. The total time for treatment can be extended beyond our estimate. Lack of facial growth, poor elastic and headgear wear, broken appliances, and missed appointments are all important factors which can lengthen the treatment time and affect the quality of the result.

For teaching and learning purposes we occasionally may need to use your protected health information.

General medical problems can effect orthodontic treatment. You should keep your orthodontist informed of any medical changes as well as medications currently being taken.

Signature: _____

Date: _____