Pediatric Medical History

Child's legal name: _____ Preferred name: _____ Date of birth: ____/____/_____
Birth sex: ❑ M ❑ F Current gender identity: _____ Pronouns: _____ Race/Ethnicity: _____ Height: ____cm Weight: ____kg
Name/age and relationship of others living in the household: _____

Primary physician: _____ Address/phone: _____ Last visit: _____
Medical specialists: _____ Address/phone: _____ Last visit: _____

Is your child being treated by a physician at this time? Reason _____ ❑ YES ❑ NO
Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? ❑ YES ❑ NO
List name, dose, frequency & date started: _____
Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department? ❑ YES ❑ NO
List date & describe: _____
Has your child ever had a reaction to or problem with an anesthetic? Describe _____ ❑ YES ❑ NO
Have you been told your child needs antibiotics or another medicine before dental treatment? Reason _____ ❑ YES ❑ NO
Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? List _____ ❑ YES ❑ NO
Is your child allergic to latex or anything else such as metals, acrylic, or dye? List _____ ❑ YES ❑ NO
Is your child up to date on immunizations against childhood diseases? ❑ YES ❑ NO
Is your child immunized against human papilloma virus (HPV)? ❑ YES ❑ NO

Please mark YES if your child has a history of the following conditions. For each "YES", provide details in the box at the bottom of this list. Mark NO after each line if none of those conditions applies to your child.

Complications before or at birth, prematurity, inherited conditions, syndromes, or birth defects (such as cleft lip/palate) ❑ YES ❑ NO
Problems with physical growth or development ❑ YES ❑ NO

Sinusitis, chronic adenoid/tonsil infections ❑ YES ❑ NO
Sleep apnea, snoring, or mouth breathing ❑ YES ❑ NO

Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease ❑ YES ❑ NO
Irregular heart beat or high blood pressure ❑ YES ❑ NO

Asthma, reactive airway disease, wheezing, or breathing problems ❑ YES ❑ NO
Cystic fibrosis ❑ YES ❑ NO
Frequent colds or coughs, bronchitis, or pneumonia ❑ YES ❑ NO
Frequent exposure to tobacco smoke ❑ YES ❑ NO

Jaundice, hepatitis, or liver problems ❑ YES ❑ NO
Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems ❑ YES ❑ NO
Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions ❑ YES ❑ NO
Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder ❑ YES ❑ NO

Bladder or kidney problems or bedwetting ❑ YES ❑ NO
Fine/gross motor deficits, arthritis, limited use of arms or legs, muscle/bone/joint problems, or scoliosis ❑ YES ❑ NO
Rash/hives, eczema, or skin problems ❑ YES ❑ NO

Impaired vision, visual processing, hearing, or speech ❑ YES ❑ NO
Developmental disorders, learning problems/delays, or intellectual disability ❑ YES ❑ NO
Cerebral palsy, brain injury, concussion, epilepsy, or convulsions/seizures ❑ YES ❑ NO
Autism/autism spectrum disorder or sensory integration disorder ❑ YES ❑ NO
Recurrent or frequent headaches/migraines, fainting, or dizziness ❑ YES ❑ NO
Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous) ❑ YES ❑ NO

Attention deficit/hyperactivity disorder (ADD/ADHD) ❑ YES ❑ NO
Behavioral, emotional, communication, or psychiatric problems/treatment ❑ YES ❑ NO
Abuse (physical, psychological, emotional, or sexual) or neglect ❑ YES ❑ NO

Diabetes, hyperglycemia, or hypoglycemia ❑ YES ❑ NO
Precocious puberty or hormonal problems ❑ YES ❑ NO
Thyroid or pituitary problems ❑ YES ❑ NO

Anemia, sickle cell disease/trait, or blood disorder ❑ YES ❑ NO
Hemophilia, bruising easily, or excessive bleeding ❑ YES ❑ NO
Transfusions or receiving blood products ❑ YES ❑ NO
Cancer, tumor, or other malignancy; chemotherapy, radiation therapy, or bone marrow or organ transplant ❑ YES ❑ NO
Corona virus disease 2019 (COVID-19), cytomegalovirus (CMV), human immunodeficiency virus (HIV)/AIDS, methicillin-resistant staphylococcus aureus (MRSA), mononucleosis, scarlet fever, sexually-transmitted disease (STD), or tuberculosis (TB) ❑ YES ❑ NO

PROVIDE DETAILS HERE: _____

Is there any other significant medical history **pertaining to this child or the child's family** that the dentist should be told? ❑ YES ❑ NO
If YES, describe _____

What is your primary concern about your child's oral health? _____

How would you describe:

your child's oral health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

your oral health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

the oral health of your other children? ❑ Excellent ❑ Good ❑ Fair ❑ Poor ❑ Not applicable

Is there a family history of cavities? ❑ YES ❑ NO If yes, indicate all that apply: ❑ Mother ❑ Father ❑ Brother ❑ Sister

Does your child have a history of any of the following? For each YES response, please describe:

Inherited dental characteristics	❑ YES	❑ NO	_____
Mouth sores or fever blisters	❑ YES	❑ NO	_____
Bad breath	❑ YES	❑ NO	_____
Bleeding gums	❑ YES	❑ NO	_____
Cavities/decayed teeth	❑ YES	❑ NO	_____
Toothache	❑ YES	❑ NO	_____
Injury to teeth, mouth, or jaws	❑ YES	❑ NO	_____
Clinching/grinding teeth	❑ YES	❑ NO	_____
Jaw joint problems (popping, etc.)	❑ YES	❑ NO	_____
Excessive gagging	❑ YES	❑ NO	_____
Sucking habit after one year of age	❑ YES	❑ NO	If YES, how long? _____ Which? ❑ Finger ❑ Thumb ❑ Pacifier ❑ Other_____

How often are your child's teeth brushed? _____ times per _____ Does someone help your child brush? ❑ YES ❑ NO

How often are your child's teeth flossed? ❑ Never ❑ Occasionally ❑ Daily Does someone help your child floss? ❑ YES ❑ NO

What type of toothbrush does your child use? ❑ Hard ❑ Medium ❑ Soft ❑ Unsure

What toothpaste does your child use? _____

What is the source of your drinking water at home? ❑ City/community supply ❑ Private well ❑ Bottled water

Do you use a water filter at home? ❑ YES ❑ NO If YES, type of filtering system: _____

Please check all sources of fluoride your child receives:

❑ Drinking water ❑ Toothpaste ❑ Over-the-counter rinse ❑ Prescription rinse/gel ❑ Prescription drops/tablets/vitamins

❑ Fluoride treatment in the dental office ❑ Fluoride varnish by pediatrician/other practitioner ❑ Other: _____

Does your child regularly eat 3 meals each day?	❑ YES	❑ NO	
Is your child on a special or restricted diet?	❑ YES	❑ NO	If YES, describe: _____
Is your child a 'picky eater'?	❑ YES	❑ NO	If YES, describe: _____
Does your child have a diet high in sugars or starches?	❑ YES	❑ NO	If YES, describe: _____
Do you have any concerns regarding your child's weight?	❑ YES	❑ NO	If YES, describe: _____

How frequently does your child have the following?

Snacks between meals	❑ Rarely	❑ 1-2 times/day	❑ 3 or more times/day	Product _____
Candy or other sweets	❑ Rarely	❑ 1-2 times/day	❑ 3 or more times/day	Type _____
Chewing gum	❑ Rarely	❑ 1-2 times/day	❑ 3 or more times/day	Usual snack _____
Soft drinks*	❑ Rarely	❑ 1-2 times/day	❑ 3 or more times/day	Product _____

(*such as juice, fruit-flavored drinks, sodas, colas, carbonated beverages, sweetened beverages, sports drinks, or energy drinks)

Please note other significant dietary habits: _____

Does your child participate in any sports or similar activities?	❑ YES	❑ NO	If YES, list: _____
Does your child wear a mouthguard during these activities?	❑ YES	❑ NO	If YES, type: _____
Has your child been examined or treated by another dentist?	❑ YES	❑ NO	

If YES: Date of first visit: _____ Date of last visit: _____ Reason for last visit: _____

Were x-rays taken of the teeth or jaws? ❑ YES ❑ NO Date of most recent dental X-rays: _____

Has your child ever had orthodontic treatment (braces, spacers, or other appliances)? ❑ YES ❑ NO If YES, when? _____

Has your child ever had a difficult dental appointment? ❑ YES ❑ NO If YES, describe: _____

How do you expect your child will respond to dental treatment? ❑ Very well ❑ Fairly well ❑ Somewhat poorly ❑ Very poorly

Is there anything else we should know before treating your child? ❑ YES ❑ NO

If yes, describe: _____

_____ _____ _____ _____

Signature of parent/guardian | Relationship to child | Date | Signature of staff member reviewing history

MEDICAL/DENTAL HISTORY UPDATE

Is your child being treated by a physician at this time? Reason _____	❑ YES	❑ NO
Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements?	❑ YES	❑ NO
List name, dose, frequency, & date started: _____		
Has your child had any illness, surgery, injury, allergic reaction, or medical emergency in the past year?	❑ YES	❑ NO
Describe: _____		
Has your child ever had a reaction to or problem with an anesthetic? Describe: _____	❑ YES	❑ NO
Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? List: _____	❑ YES	❑ NO
Is your child allergic to latex or anything else such as metals, acrylic, or dye? List _____	❑ YES	❑ NO
Have there recently been any significant changes/disruptions to your child's family, home, or school routines?	❑ YES	❑ NO
Describe: _____		
What is your primary concern regarding your child's oral health? _____		
Has your child had any tooth pain or injury to the mouth/teeth/jaws since last visiting our office?	❑ YES	❑ NO
Describe: _____		
Has your child's diet changed significantly since his/her last dental visit? Describe: _____	❑ YES	❑ NO
Has your child been treated by another dentist/dental professional since last visiting our office? Reason: _____	❑ YES	❑ NO
Is there any other change in the child's medical, dental, or family history that the dentist should be told?	❑ YES	❑ NO
Describe: _____		

_____ _____ _____ _____

Signature of parent/guardian | Relationship to child | Date | Signature of staff member reviewing history

SUPPLEMENTAL HISTORY QUESTIONS FOR AN INFANT/TODDLER

Was your child born prematurely? ❑ YES ❑ NO If YES, what week? _____

What was your child's birth weight? _____

How long was your child breastfed? ❑ N/A ❑ less than 6 months ❑ 6-11 months ❑ 12-17 months ❑ 18-23 months ❑ 2 years or more

How long was your child bottle-fed? ❑ N/A ❑ less than 6 months ❑ 6-11 months ❑ 12-17 months ❑ 18-23 months ❑ 2 years or more

Do/did you feed your child infant formula? ❑ YES ❑ NO If YES, what type? (check one): ❑ Ready to use ❑ Powdered ❑ Liquid concentrate

Does/did your child sleep with a bottle? ❑ YES ❑ NO If YES, content of bottle? _____

Does/did your child use a no-spill training cup (sippy cup)? ❑ YES ❑ NO

Child's age (in months) when first tooth appeared in mouth _____

Has your child experienced any teething problems? ❑ YES ❑ NO

When did you begin brushing your child's teeth? ❑ N/A ❑ before age 6 months ❑ 6-11 months ❑ 12-17 months ❑ 18-23 months ❑ 2 years or more

When did you begin using toothpaste? ❑ N/A ❑ before age 6 months ❑ 6-11 months ❑ 12-17 months ❑ 18-23 months ❑ 2 years or more

Who is your child's primary care taker during the day? _____ during the evening? _____

Name/age of siblings at home: _____

_____

_____ _____ _____ _____

Signature of parent/guardian | Relationship to child | Date | Signature of staff member reviewing history

SUPPLEMENTAL HISTORY QUESTIONS FOR AN ADOLESCENT PATIENT (to be completed by the patient)

For each YES response, please describe:

Do you have any concerns about your mouth, teeth, or oral health? ❑ NO ❑ YES _____

Have you recently experienced any dental/oral pain? ❑ NO ❑ YES _____

Do you have any concerns with the appearance of your teeth or smile? ❑ NO ❑ YES _____

Do you bleach your teeth? ❑ NO ❑ YES _____

Have there been any recent changes in your dietary habits? ❑ NO ❑ YES _____

Are you taking any dietary or herbal supplements? ❑ NO ❑ YES _____

Do you participate in sports or high speed activities (for example skiing, four-wheeling, motorcycling)? ❑ NO ❑ YES _____

We recognize that patients may engage in certain behaviors/activities that can have significant consequences on their oral health and/or general health. In addition, medicines that we use to treat oral conditions may interact with drugs (prescription, over-the-counter, or recreational) and other substances a patient might be using. Therefore, we encourage our adolescent patients to answer all of the following questions truthfully. If you prefer not to answer an item, we hope you will discuss any concerns confidentially with your dentist.

Do you have any history of:

Oral habits (chewing fingernails, clenching/grinding teeth, etc.)	❑ NO	❑ YES	❑ PREFER NOT TO ANSWER
Tobacco use (cigarette, pipe, cigar, bidi, snuff, spit, chew, etc.)	❑ NO	❑ YES	❑ PREFER NOT TO ANSWER
Electronic cigarette (e-cig) use	❑ NO	❑ YES	❑ PREFER NOT TO ANSWER
Eating disorder (anorexia, bulimia, etc.)	❑ NO	❑ YES	❑ PREFER NOT TO ANSWER
Oral piercings/jewelry (including grill)	❑ NO	❑ YES	❑ PREFER NOT TO ANSWER
Alcohol or recreational drug use/prescription abuse	❑ NO	❑ YES	❑ PREFER NOT TO ANSWER
Inhalant use/abuse (such as huffing)	❑ NO	❑ YES	❑ PREFER NOT TO ANSWER
Sexual activity (including oral sex)	❑ NO	❑ YES	❑ PREFER NOT TO ANSWER
Abuse (physical, sexual, verbal, mental)	❑ NO	❑ YES	❑ PREFER NOT TO ANSWER
Anxiety, depression, or feeling helpless/hopeless	❑ NO	❑ YES	❑ PREFER NOT TO ANSWER
Females: Are you pregnant or possibly pregnant?	❑ NO	❑ YES	

Is there anything you would like to discuss confidentially with your dentist? ❑ NO ❑ YES

Would you like to discuss a referral to a family dentist or general dentist because of your age? ❑ NO ❑ YES

_____ _____ _____

Signature of patient | Date | Signature of staff member reviewing history

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 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. This Notice takes effect 4 / 1 / 03 , 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 any 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 HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use or disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing 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 an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

To Your Family, Friends and Persons Involved In Care: 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. We may use or disclose health information 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, of your location, your general condition, or death. 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.

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

Public Health Activities: We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Court Orders and Subpoenas: We may disclose information in response to an appropriate court order or subpoena.

Law Enforcement: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

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 institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters). We may also contact you to provide information about treatment alternatives or other health-related information that may be of interest to you.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time.

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 additional requests.

Restriction: 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).

Alternative Communication: You have the right to request that we communicate with you about your health information 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.

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 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 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 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 the U.S. Department of Health and Human Services.

Contact Officer: Michigan Orthodontics Specialist

Telephone: 248 559-4800 Fax: _____

Email: _____

Address: 29702 #H Southfield Rd
Southfield MI 48076

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

I, _____ , have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

Dr. Jana Tumpkin McQueen Michigan Orthodontic Specialists is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other _____
	Relationship to patient, First , Last name and Date of Birth
☐ DENTIST: List Doctor's/Pratice Name, Address & Phone number:	
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedure) ☒ Other **DR JANA TUMPKIN MCQUEEN MICHIGAN ORTHODONTIC SPECIALISTS: SOUTHFIELD, DEARBORN & CLINTON TOWNSHIP, MI.**	☐ May be posted in office ☐ May be posted on website ☐ Other _____

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

_____

Revised Oct 2014

SUPPLEMENTAL
HEALTH QUESTIONNAIRE

If you have been exposed to a communicable disease, you may spread the disease to the orthodontist, orthodontic staff, or other patients/parents in the practice. Therefore, prior to each appointment, we will be asking the following questions to reduce the chances of transmission:

Do you, your child, others accompanying you to today's appointment or anyone you have recently been in contact with have any of the following symptoms?

Fever *(defined as above 99.6 degrees)*?	☐ Yes	☐ No
Cough?	☐ Yes	☐ No
Shortness of breath and/or trouble breathing?	☐ Yes	☐ No
Persistent pain, pressure, or tightness in the chest?	☐ Yes	☐ No

Have you, your child, others accompanying you to today's appointment or anyone you have recently been in contact with tested positive for or been diagnosed as having COVID-19 or any other communicable disease? ☐ Yes ☐ No

If yes provide approximate dates of illness _____

☐ I understand that if the answer to any of these questions is yes, I may be asked to reschedule today's orthodontic appointment to a later date.

_____ _____

Patient/Parent's Signature Date

American Association of Orthodontists®

SUPPLEMENTAL
INFORMED CONSENT

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus," at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, orthodontist, orthodontic staff and sometimes other patients at all times.

Although exposure is unlikely, do you accept the risk and consent to treatment?

☐ Yes ☐ No

_____ _____

Patient/Parent's Signature Date

American Association of Orthodontists®