MODERNZEN
ORTHODONTICS

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INSTRUCTIONS

Thank you for scheduling a new patient consultation for an orthodontic evaluation with Dr. Robles. Dr. Robles provides an initial "complimentary" consultation in that your out of pocket fee will be waived. In order for a thorough evaluation to be performed, orthodontic records will need to be taken. The cost for these initial records will be submitted to your dental insurance, and if you decide to start, will be discounted from your orthodontic treatment. However, if you would like a copy of these records* after your initial consultation, there may be a records fee involved. (*photos, panoramic x-ray and cephalometric x-ray). _____ Please set aside 20-30 minutes to fill in the forms below.

TIPS:

- If the question is not applicable, please enter N/A for that answer field.
- Enter a cell phone number (not a landline) and a valid email address so that you may receive a courtesy automated reminder before your scheduled date and time.
- For check boxes, please make sure you "click" on the box so a check mark appears in that area.
- Click "FINISH" toward the top right when you have completed.

(CHILD) DATE:

PATIENT INFORMATION

Patient's First and Last Name:	Check: Male / Female
Patient's Address:	
Marital Status of Parents: M S D W	Patient's Birth Date:
Patient's Home Phone: Who does the above home phone belong to? Mom Dad Other	Patient lives with: Mom: FT PT FT (Full Time) PT (Part Time) Dad: FT PT Both Mom & Dad: Other:
Secondary Phone Contact in case of schedule changes:	
Mother's Name:	Mother's Email:
Father's Name:	Father's Email:
Patient's General Dentist Name:	
General Dentist Address/Phone:	

RESPONSIBLE PARTY INFORMATION

How many responsible parties?	Relationship to Patient:	
Name:		Birth Date:
Address:		
City:	State:	Zip Code:
Phone:	2nd Phone Contact in case of schedule changes:	

2nd Responsible party Name:		Birth Date:
Address:		
City:	State:	Zip Code:
Phone:	2nd Phone Contact in case of schedule changes:	

INSURANCE INFORMATION

Subscriber's Name on Card:		Birth Date:
Ins Comp:	ID#	SSN:
Employer Name:		Group No#

Responsible Party Full Name Responsible Party Signature

How did you hear about us?

New Patient Medical History Form

Date: _____

Patient's First and Last Name: _____ DOB: _____

Parent(s) / Guardian's Full Name: _____

Responses to Patient Health Questionnaire:

	Y	N		Y	N
• Is patient in good health?			• Excessive bleeding?		
• Heart Problems?			• Herpes?		
• Low blood pressure?			• Malignancies?		
• High blood pressure?			• Thyroid problems?		
• Taking blood pressure meds?			• History of mumps?		
• HIV positive?			• History of measles?		
• Allergies to medication?			• History of rheumatic fever?		
• Allergies to metals?			• Receiving psychiatric care?		
• Allergies to latex or balloons?			• Sinus problems?		
• Asthma?			• History of scarlet fever?		
• Arthritis?			• History of stroke?		
• Epilepsy?			• Radiation treatments?		
• Diabetes?			• Birth control pills?		
• Hepatitis?			• Pregnant?		

Any history of taking antibiotics BEFORE a dental treatment? Y N
(If yes – please explain below)

Any history of thumb sucking, finger sucking, gum chewing, nail biting, tongue sucking or tongue thrust?
Y N
(If yes – please explain below)

Any further comments you'd like us to be aware of?

(Please explain Yes answers below)

_____

_____

_____

Patient (Parent/Guardian if minor) SIGNATURE

AIRWAY / Pediatric Sleep Questionnaire: Sleep-Disordered Breathing Subscale

Please answer these questions regarding the behavior of your child during sleep and wakefulness. The questions apply to how your child acts in general during the past month. You should circle the correct response.

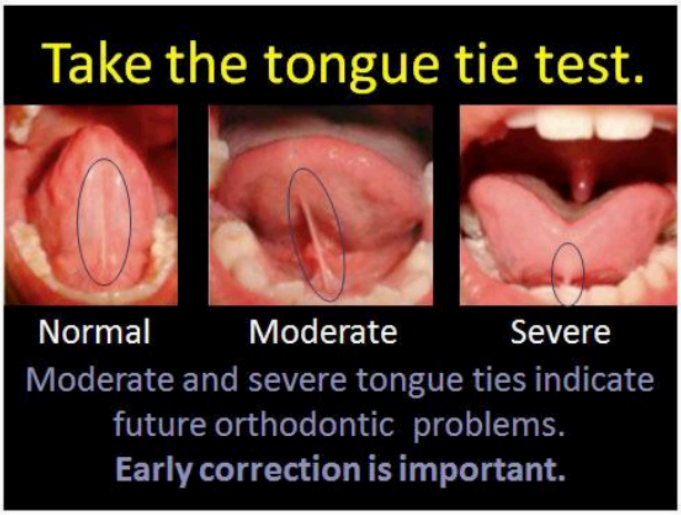
A "Y" means "yes", "N" means "no," and "DK" means "don't know."

	Y	N	DK	A2
1. WHILE SLEEPING, DOES YOUR CHILD: Snore more than half the time?……. Always snore?……...…….. Snore loudly? …….. Have "heavy" or loud breathing?……..... Have trouble breathing or struggle to breathe?…….				
2. HAVE YOU EVER SEEN YOUR CHILD STOP BREATHING DURING THE NIGHT?				
3. DOES YOUR CHILD: Tend to breathe through the mouth during the day?……. Have a dry mouth on waking up in the morning? …….. Occasionally wet the bed? …….....				
4. DOES YOUR CHILD: Wake up feeling unrefreshed in the morning?……. Have a problem with sleepiness during the day? ……..				
5. HAS A TEACHER OR OTHER SUPERVISOR COMMENTED THAT YOUR CHILD APPEARS SLEEPY DURING THE DAY?				
6. IS IT HARD TO WAKE YOUR CHILD UP IN THE MORNING?				
7. DOES YOUR CHILD WAKE UP WITH HEADACHES IN THE MORNING?				
8. DID YOUR CHILD STOP GROWING AT A NORMAL RATE AT ANY TIME SINCE BIRTH?				
(Left Blank)				

	Y	N	DK	A2
9. IS YOUR CHILD OVERWEIGHT?				
10. THIS CHILD OFTEN: Does not seem to listen when spoken to directly…….....…… Has difficulty organizing tasks and activities……..... Is easily distracted by extraneous stimuli……..... Fidgets with hands or feet or squirms in seat…….....….. Is "on the go" or often acts as if "driven by a motor"……..... Interrupts or intrudes on others (ex: butts into conversations/ games)…......				

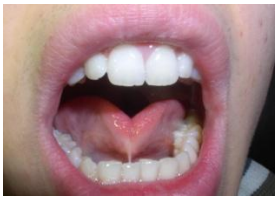
The 22 items of the SRBD Scale are each answered yes=1, no=0, or don't know=missing. The number of symptom-items endorsed positively ("yes") is divided by the number of items answered positively or negatively; the denominator therefore excludes items with missing responses and items answered as don't know. The result is a number, a proportion that ranges from 0.0 to 1.0. Scores 0.33 are considered positive and suggestive of high risk for a pediatric sleep-related breathing disorder. The threshold is based on a validity study that suggested optimal sensitivity and specificity at the 0.33 cut-off.

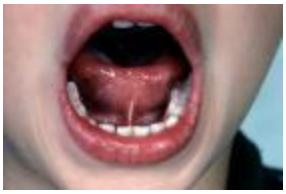
**** DOES YOUR CHILD HAVE THEIR ADENOIDS/TONSILS? YES NO**



PLEASE CHECK BELOW:

Normal		Can touch the roof of the mouth with the tip of tongue.
Moderate		Can lift the tongue halfway up.
Severe		Tongue develops a "U" shaped form when lifting.





Downward protrusion shows deep notching and midline groove – this can get deeper and wider if not treated.

Ankyloglossia

The terms 'ankyloglossia', 'short frenum', 'short frenulum', or 'tongue tie', refer to a restricted lingual fraenum due to a consolidation of tissue, usually leading to reduced mobility of the tongue. It is commonly observed that a person with tongue-tie cannot protrude the tongue tip beyond the edges of the lower incisors, or to the maxillary alveolar ridge (behind the upper incisors). Sometimes when a person with tongue-tie attempts to protrude the tongue it forms a characteristic 'W' shape.

Potential effects of tongue-tie

- ***Speech development*** – It is important to note that tongue-tie does not necessarily impair speech. Many individuals compensate well and have normal sounding speech, even those with the frenum attached very close to the tongue tip. Some individuals with tongue-tie may have imprecise articulation, especially at speed.
- ***Dental health*** – Cavities "dental caries' can occur due to food debris not being removed by the tongue's action of sweeping the teeth and spreading saliva. Gingivitis (gum disease) can develop and halitosis (bad breath) may be present. Without the development of proper tongue position, the development of the roof of the mouth (palate) is affected which could cause restricted development of the palate which could lead to the need for orthodontic treatment.
- ***Eating and digestion*** – Some children with tongue-tie are messy eaters due to a restricted ability to tidy up inside and outside of their mouths while they are having a meal. Some are unable to circle their lips with their tongues in order to fully lick their lips. In extreme cases poor oral hygiene can lead to digestive complaints.
- ***Appearance*** – the tongue can be unduly obvious or unusual looking in some individuals, especially those that had a tongue tie most of their life. This would result in deep fissures in the middle of the tongue in adults which in turn cause food and bacteria to easily wedge into.
- ***Dental misalignment*** - Tongue tie affects the resting position of the tongue. It may be too far forward in the mouth, and it might constantly push against the front teeth and gaps and tooth movement will occur, leading to the need for orthodontic treatment.
- ***Restricted jaw development*** - Severe cases of tongue tie can seriously hinder the development of the jaw, causing it to be smaller than it should. This can affect facial esthetics and **increase the risk of obstructive sleep apnea** and TMJ dysfunction.

SUPPLEMENTAL INFORMED CONSENT

Orthodontic Treatment in the Era of COVID-19

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.

If you or your child are experiencing flu-like symptoms or have a temperature, please CANCEL your appointment ahead of time. Call us back to reschedule your child's appointment once you or your child are free of symptoms. We have the right to ask you and your child to leave the premises immediately if you or your child have these symptoms and ask that you and your child self-quarantine yourself for 14 days. You are advised to seek medical help immediately to test for COVID-19. Once you and your child are symptom free, please call us or email us to request for a new appointment.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you or your child 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 of your child?

Yes ___ No ___

Parent's Signature_____ DATE: _____

SUPPLEMENTAL INFORMED CONSENT

Delivery of Orthodontic Services by Teledentistry

When you start orthodontic treatment, on rare occasions, you might receive orthodontic services via Teledentistry (virtual appointment) which involves using electronic and digital communications between you as a patient or parent and your orthodontist. In providing Teledentistry services, our practice will follow the rules and regulations of the state dental board(s) in which the doctor is licensed.

THERE ARE RISKS AND LIMITATIONS WITH TELEDENTISTRY FOR ANY DENTAL TREATMENT INCLUDING ORTHODONTICS:

- In-person office visits are preferred for the best orthodontic outcomes. Teledentistry involves risks that an office visit might avoid, and Teledentistry is best used when an office visit is impractical or in between regular office visits. Your orthodontist will use his/her best judgment in determining when Teledentistry is appropriate.

- Teledentistry, as offered by Dr. Robles is only available for patients **requiring observation visits** that do not need any timely adjustments as determined by Dr. Robles. If there is an issue (such as a broken or loose brackets/wires/appliances), before your virtual appointment, then it is highly recommended that you contact our office at (301) 900-8010 or email us immediately at info@ModernZenOrthodontics.com, in order for an adjustment to be performed in order to relieve this issue. You can use that same time/day slot that was scheduled for your virtual appointment to come in, but you still need to let us know if you are coming in.

- When using electronic and digital communication in the provision of care, there is potential for the breach of confidentiality and/or inadvertent access of protected health information by someone other than your orthodontist, as well as a risk that a loss of electronic communication could mean the loss of Teledentistry services.

- The photography or digital imaging you provide to us (through your video camera accessed from either your phone, laptop or computer), can only give a superficial view and may be inadequate to identify all areas of concern. Although we strive to provide excellent service using Teledentistry, treatment or recommendations based solely on Teledentistry may not allow adequate monitoring of unexpected responses to treatment. Teledentistry is not meant to provide a diagnosis or adequate monitoring of other oral conditions. This is conducted through an in-office visit with your General Dentist.

Do you understand the risks and limitations of Teledentistry, and hereby consent to forwarding patient-identifiable information to our practice using electronic communications? Yes___ No ___

Consent to treatment using Teledentistry? Yes___ No___

Parent's Signature _____ Date: _____

INSTRUCTIONS
Please submit the following:

- A copy of a government issued identification with your photo (ex., drivers license or passport).

- Your insurance card so we can follow up with them regarding any orthodontic benefits you or your child may have.

_____ _____

FULL NAME of Responsible Party (connected to insurance card)

SIGNATURE

_____

PATIENT NAME