Rick Van Tran, DDS

521 East Center Street
Manteca, CA 95336
(209) 823-9218 (office) · (209) 823-1134 (fax)

Orthodontic Evaluation

Patient Name: _____ Age: _____ Date: _____

Dental/Skeletal Classification

___ Class I
___ Class II ___ Div I ___ Div II
___ Class III
___ Bimaxillary Protrusion
___ Skeletal Appearance

Airway

___ Deviated Septum
___ Allergies/Asthma
___ Venous Pooling
___ Tonsils: 1 2 3 4
___ Mouth Breathing
___ High Palatal Vault
___ Constricted Nares
___ Cloudy Sinuses
___ Snoring
___ Other:

Dentition

___ Crowding: 1 (mild) 2 3 4 5 (severe)
___ Missing Teeth
___ Anomalies
___ Active Caries
___ Overbite/Overjet

Oral Conditions

___ Hygiene: 1 (mild) 2 3 4 5 (severe)
___ Finger/Thumb Sucking
___ Thick Frenums: max mand
___ Gingival Recession
___ Tongue Thrust Swallow

Other Conditions (TMD, Recession, Anomalies, etc): _____

_____

Notes: _____

_____

Cost of Treatment

Orthodontic Records: $_____
Special Appliance Fees: $_____
Fee for Phase I: $_____
Fee for Phase II (not included in phase I): $_____
Total Fee: $_____

Approximate Treatment Time

Months _____

Phase I (Orthopedics) _____
Phase II (Orthodontics) _____

Orthodontic Flow Sheet

Patient Name: _____ DOB: _____ Date: _____

Appointment #1 Diagnostic Workup (1 Hr)

___ Chair Side Analysis
___ Study Models
___ Panolipse Radiograph
___ 7 Series/ 4 Bitewings Radiographs
___ TMJ Screening
___ Digital Photos (9)
___ Centrix Occlusion Wax Bite
___ Cephalometric Radiograph
___ Transcranial Radiograph
___ Prepared Orthodontic Consultation

Appointment #2 Consult; Financial Records, Separators Placement (1 Hr)

___ Consultation with Patient/Guardian/Responsible Party
___ Consent/Information Forms reviewed and signed
___ Release Form reviewed and signed
___ Financial Arrangements reviewed and signed
___ Placement of Separators for 1st molar bands

Appointment #3 Brackets/1st Molar Bands/Appliances (2 Hrs)

___ Impression for appliance: Y N ___ Type of Appliance: _____
___ Brackets (mgfr. & Rx): _____
___ 1st Molar Bands (mgfr. & Size) UR ___ UL___ LR ___ LL___ Mgfr: _____
___ Initial Wire Placed Separators placed for 2nd Molar Bands
___ Sonicare/Hydrofloss discussed. Dispensed: Y N
___ OHI ___ Ortho Care Package ___ Home Fluoride Dispensed Y N

Appointment #4 Band 2nd Molars (1 Hr)

___ 2nd Molar Bands (mgfr. & Size) UR ___ UL___ LR ___ LL___ Mgfr: _____

Completed Case Final Records and Deliver Retainers (2 Hrs)

___ Chair Side Analysis
___ Study Models
___ Panolipse Radiograph
___ 7 Series/ 4 Bitewings Radiographs
___ TMJ Screening
___Upper Retainers Delivered
___ Digital Photos (9)
___ Centrix Occlusion Wax Bite
___ Cephalometric Radiograph
___ Transcranial Radiograph
___ Fluoride Tx & Post Care Instructions
___ Bonded Lower 3x3/Lower Retainer DEL

Case Completed (Date): _____

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Orthodontic Patient Information and Consent Form

We appreciate your confidence in selecting our office for your orthodontic treatment. We want you to be fully informed and feel free to ask questions at any time. Please understand that an important part of your treatment includes making dental arch models, x-rays, and photographs for your records, some of which may be taken several times during the course of treatment.

As a rule, excellent orthodontic results can be achieved with an informed and cooperative patient. To help achieve this end we routinely supply the following information to all of our patients who are considering orthodontic treatment. While recognizing the benefits of a pleasing smile and healthy functional teeth, you should also be aware that orthodontic therapy, like any other health treatment of the body, has some hazards, inconveniences and limitations. These problems are usually overcome and seldom outweigh the long-term benefits, but need to be considered when making a decision to wear orthodontic appliances (braces).

Discomfort: When appliances are first fitted, and sometimes at the regular visits when the appliances may be adjusted or modified, the patient can expect some discomfort and perhaps even soreness. This discomfort usually disappears after a few days. If it persists longer, please call us, as we may need to examine the patient and perhaps modify the appliance adjustments.

Dental Hygiene: Decalcification (permanent markings on the teeth), tooth decay or gum disease can occur during orthodontic therapy if patients do not brush and floss their teeth properly as instructed. Chewing gum, candy, excessively sweet between-meal snacks are to be eliminated. Regular checkups and cleanings at our office need to be scheduled a minimum of every six months, to check for decay, gum problems, and to clean teeth. Occasionally gum disease problems that were present before orthodontic treatment may be worsened by the wearing of the braces, and this may require further dental treatment of a non-orthodontic nature. We cannot stress enough the importance of regular dental care when in orthodontic care.

Irregularities of Teeth: Tooth positions change constantly throughout life, whether an individual has worn braces or not. After orthodontic treatment is completed, and braces removed, patients are subject to the same subtle changes in tooth position that occur in non-orthodontic patients. During their late teens and early 20s, some orthodontic patients may notice that slight irregularities of tooth position can develop, particularly if the front teeth were extremely crowded before treatment began. Long-term war of retainers may be the only way to minimize this problem if it becomes noticeable.

Non-Orthodontic Care: Cold sores, canker sores, and irritation or injury to the mouth are possible while wearing braces. Allergic reactions to some of the dental materials or medicates are rare, but can occasionally occur. There may be need for extraction of some teeth, or even the need to replace fillings, crowns, bridges, or perhaps to obtain periodontal (gum) treatment or other dental procedures during or following orthodontic therapy. If such treatment becomes necessary this is not deemed part of the orthodontic treatment and the patient will need to seek out a general dentists or dental specialist to perform such procedures.

Potential Problems Encountered in Orthodontic Treatment

Nerve Injury: On rare occasions, while orthodontic treatment is under way, the nerve of a tooth may flare up to become inflamed or diseased. Usually this can be traced to a past injury or even a deep filling in the tooth done previously. If nerve treatment or endodontic procedures become necessary, this is not considered part of the orthodontic treatment.

Resorption of Root Tips: In some instances, the tips of the teeth may be seen to shorten slightly during orthodontic treatment. This is called root resorption. However, under most circumstances, these slightly shortened roots pose no disadvantage. There is no way to foresee whether this will occur and nothing can be done to prevent this from happening.

TMJ Dysfunction: There is a chance that some pain or discomfort can occur in the lower jaw joints (TMJ dysfunction). The aligning of the teeth to a more normal occlusion or the level of bite being corrected, usually removes the problem. However, in some rare cases, other non-orthodontic treatment may be needed by another dentist.

Growth Spurts: Occasionally, a person who has grown normally up to the age where orthodontic treatment may not continue to do so. If these growth changes produce disproportionate problems, in which the jaw position is affected, the original treatment objective may have to be reevaluated and the course of treatment altered to meet the new circumstances. Such skeletal disharmony is a biological process of body growth, and may be beyond the dentist's control using orthodontic appliances alone.

Patient Cooperation: Successful orthodontic treatment can be brought about only through the cooperation of all parties involved. Arriving at the office on time for appointments, having the patient take excellent care of his/her teeth during the treatment phases, and wearing all appliances with good grace and excellent cooperation will go far to help the dentist succeed in reaching the orthodontic goals envisioned at the start. If the patient does not wear the appliances, headgear, elastic bands, or tooth positioners or retainers, exactly as instructed by the dentist, then such lack of cooperation will lessen the success of the orthodontic therapy or lengthen the treatment time, or both.

I have read carefully, and understand this letter of information. I hereby give my consent to the orthodontic treatment outlined by Dr. Rick Van Tran. It is to be understood that the undersigned dentist is not a board certified orthodontist.

_____ _____
Patient/Parent/Guardian/Responsible Party's Signature Date

_____ _____ _____
Patient Name DOB/Age Date

_____ _____
Treating Dentist's Signature Date

Note: this form will be retained in the patient's dental records, where you may examine it at any time during the treatment.

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Informed Consent and Treatment Confirmation

I certify that the Orthodontic Patient Information Form outlining general considerations and potential problems and hazards of orthodontic treatment was presented to me, and I have read and understood its contents. I have had the opportunity to discuss it with Dr. Rick Van Tran to clarify any areas I did not understand. I authorize Dr. Rick Van Tran to provide orthodontic treatment for _____.
Patient's Name

The prescribed treatment was explained to me on _____. I further understand that, like the other healing arts, the practice is not an exact science, therefore results cannot be guaranteed. It has been explained that Dr. Rick Van Tran is not an orthodontist, but instead of general dentist who practices orthodontics.

Signed: _____ Date: _____
Parent/Guardian/Patient Signature

I also give my permission that any records made during the process of examination, treatment, and retention may be used for the purposes of research, education, or publication in professional media.

Signed: _____ Date: _____
Parent/Guardian/Patient Signature

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Orthodontic Financial Contract

Contract for orthodontic treatment of _____.

So that there will be a better understanding of the financial arrangements before treatment begins, we are providing this letter explaining to you, the responsible party, our office policies.

- Contract amount for orthodontic treatment: $ _____.
  - Note: This fee does not include the orthodontic records fee of $250, which is due at time of service.
- Total Contract Amount (plus orthodontic records fee ($250)) = _____
- Estimated Insurance Coverage: $ _____
- Total Fee – Insurance Coverage = estimated out-of-pocket amount of $ _____
- If requesting payment plan:
  - Down payment of $ _____ due when appliances are placed on _____.
  - Total # of monthly payments: _____.
  - Monthly Amount: $ _____

☐ **Payment Plan**

_____ Monthly payments in the amount of $ _____ payable and due on _____ of each month beginning _____.

☐ **Paid in Full**

Total contract amount, including orthodontic records, of _____ will be paid in full prior to treatment.

NOTE: Patient is responsible for any amount not covered by the insurance company.

The fee breakdown will include our diagnosis and treatment plan, regular office visits, appliances, and two years of retainer visits. It will not include the loss of appliances, repair of appliances or braces damaged through negligence, additional treatment, late payment charges, nor charges for services not provided by our office.

Please understand that this fee is for total treatment rendered and is not directly related to the time to complete treatment. We have extended the payment of this fee over a monthly period as a convenience to you; actual treatment may be shorter or longer than the monthly period. **However, payment for treatment is due in full prior to completion of treatment unless other financial arrangements have been made with our office.**

Our services will be discontinued due to failure to adhere to the financial arrangements. Treatment will continue when your account is brought up to date or other arrangements are made. **Treatment will also be discontinued due to lack of cooperation from the patient after discussion of the problem with the patient and/or parents.**

We will provide you a monthly coupon book and will not send you statements unless there are additional charges or the account becomes delinquent. Please place the patient's full name on each payment check.

- A charge of $75 per month will be made for treatment that extends past 3 months due to poor cooperation. Excessive breakage and missed appointments can delay treatment in addition to incurring charges of $20 per bracket or missed appointment if there are 5 or more occurrences.

- There will be a NSF charge of $30 for any checks that are returned to our office and will not accept checks as a means of future payments. We will only accept cash, credit cards, cashiers checks or money orders.

Your treatment is a team effort. As such, your regular examination appointments should be maintained with our office during orthodontic treatment at 6 month intervals. In fact, we may suggest routine visits at three to four month intervals if found necessary.

I understand the financial arrangements above and agree to comply with them. I agree that parents are the responsible party for all fees and services rendered for treatment of a child. I understand that I am responsible for **ALL** fees regardless of insurance coverage. I also understand that as treatment progresses, the above fees may need to be adjusted, but that I will be informed of these adjustments and how they will affect my payment plan. In the event that my payments are not received within 30 days of their due date, I agree to pay all costs of collection, including, but not limited to reasonable attorney fees.
Please file this letter for future reference. If you should have any questions regarding your account or if you would like a copy of the account status at any time, please contact our office and we will be happy to assist you.

_____ _____
Patient/Parent/Guardian/Responsible Party's Signature Date

_____ _____
Treating Dentist's Signature Date

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Orthodontic Office Procedure and Instructions

Since we have less than two hours of office time after school hours, and most of our patients are school children, it is necessary that we see many of our patients during school hours. Appointments require more than one unit of time must be made during school hours. We apologize in advance for an inconvenience this may cause you.

Regularity in keeping appointments is extremely important to maintain steady progress. The patient will be given the time for their appointment at the end of each visit. We realize there may be occasions when there is a misunderstanding about an appointment time or some uncontrollable factor causing an appointment not to be kept without prior notice to us. This is called a **BROKEN APPOINTMENT.** We have made it a policy to not charge for the first two (2) broken appointments, **however**, beginning with the **THIRD** broken appointment, there will be a $25 charge for each broken appointment thereafter. If you are more than 15 minutes late to an appointment, you will need to see the front desk to reschedule your appointment for another time.

A routine cleaning and examination for decay is to be done on a periodic basis, as this is not part of orthodontic treatment. This is an important service and must not be neglected. Check to see if we have you on a periodic recare basis. We should see you at six-month intervals, unless otherwise specified by our hygienist or Dr. Rick Van Tran. Good oral hygiene is a necessity, and brushing should be done after eating any food.

Extra effort should be spent on brushing and flossing for treatment to go as planned. Consistently neglecting this health procedure may cause treatment to be discontinued. The presence of any type of appliance creates new surface for food particles, making cleaning more difficult, more time consuming, and more important.

Some soreness may be expected after the placing of appliances and following certain adjustment appointments. This is due to a new stress of the teeth created by the appliances. Instructions will be given to the patient to relieve this discomfort. A soft diet may be necessary for the first two days following these appointments.

Instructions are also given to the patient about certain foods that should be eaten during the period of treatment and certain habits that must be avoided. **Bubble gum, sticky foods, candies, and cookies, and the biting of hard candy, or eating ice is destructive, for these pressures will break or bend the appliances.** Picking at the appliance with the fingers or playing with them with the tongue may damage the appliances and thereby lengthen treatment. If there is breakage, please save all parts and call for an appointment. Loose bands should always be recemented as soon as possible.

Cooperation is necessary with the wearing of elastics, headgear, or retainers – exactly as instructed. If elastics are to be worn all the time, they should be left off only long enough to eat or brush the teeth. Extra elastics should be carried with the patient at all times so that if the elastic breaks, another can be placed on immediately.

Normal wear and tear on appliances is expected. Unwarranted breakage or loss of appliances will require an additional charge. There is a minimum charge of $200 for replacement of lost or broken retainers. Charges for routine dental services are not included in this fee.

If it becomes apparent that treatment is suffering because of poor cooperation or improper brushing, you will be notified. If this poor cooperation continues after notification, we will set up a consultation appointment with the patient and/or parent to review the problem. Poor cooperation is costly not only in lengthening treatment time, but can increase the fee for treatment.

We also will not be responsible for any damage that may occur due to patient's lack of good oral hygiene.

If you have any questions regarding the proposed treatment, its progress, or our office procedure, please communicate with us, for we are anxious to have a successful result and pleasant relationship.

To assure our mutual understanding, please sign and date this agreement.

_____ _____
Patient/Parent/Guardian/Responsible Party's Signature Date

_____ _____
Treating Dentist's Signature Date

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Orthodontic Care Information Sheet

I, _____, patient/guardian of: _____ or the patient, agree to the treatment plan presented by Dr. Rick Van Tran and staff for orthodontic services. I understand that the payment agreed to per month has no relation to the number of orthodontic visits necessary to complete care. I understand that the monthly payments are simply a financial arrangement to allow me to pay for the orthodontic treatment. I further understand that my payment is due each month as per agreement until paid in full, whether I or _____ receives orthodontic "wire tightening" or not. I understand that in some months, but not in all cases, I or _____ may not receive orthodontic care. I understand that I am still responsible for my monthly payment as agreed to, if applicable.

_____ _____
Patient/Parent/Guardian/Responsible Party's Signature Date

_____ _____
Dr. Rick Van Tran and/or Staff Date