Islington Green Dental Practice
66 Upper Street, Islington Green, London N1 0NY
T: 020 7226 0849 E: info@igdp.co.uk W: www.igdp.co.uk

HEALTH HISTORY FORM (Only complete pages 1 & 2 if you have not done this online)

Patient Name (Surname)_____
(First Name)_____ (M. I.)_____

☐ M ☐ F Date of Birth_____ Age_____

_

How did you hear about FASTBRACES?_____

Home Address_ _____ _

_____ Postcode _____
Home Tel _____ Mobile
_ _____

Emergency Contact _____ Relationship _____ _

Tel_____

If Applicable: Who's accompanying the child today?_____
(Circle if you do not have legal custody of this child: N)

Person responsible for account _____ _____
Occupation_ _____ Relationship

Billing Address_____

_____ Postcode _____

Email_____

Who is your general dentist?_____ _
Tel_____ Last Visit_
_____

Who else has examined you?_____

Every page of this agreement has to be initialed.

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PATIENT MEDICAL AND DENTAL HISTORY • CIRCLE ALL THAT APPLY

Women: Pregnant, Nursing.

Are You Allergic to: Any Metal, Plastics, Other:_____

Have You Ever Had: Jaw Pain, Jaw Lock (Couldn't Open Or Close), Jaw Popping Or Clicking, Injury To The Face Or Head, Ear Pain, Severe Headaches, Blood Disorder, Diabetes, Hepatitis A or B or C, HIV or AIDS or ARC, High Or Low Blood Pressure, Kidney Problems, Liver Disease, Organ Transplants, Artificial Joints Or Bones, Hemophilia, Heart Murmur, Heart Surgery, Heart Attack Or Stroke, Pacemaker, Epilepsy, Tuberculosis, Congenital Defect, Radiation Therapy, Paralysis, Transfusion, Cancer, Chemotherapy, Psychiatric Problems Or Depression, Brain Disorder,

Other:_____

Do You Need To Be Pre-medicated? Yes / No
Your Health Is: Good / Poor
Do You Take Any Prescription Drugs? Yes / No. Which Ones?

_____

Are you allergic to: Aspirin, Dental Anesthetics, Penicillin, Erythromycin, Tetracycline and Codeine. Yes/No
Do you grind your teeth? Yes / No
Do you have any speech problems? Yes / No

Have You Ever Had: Anemia, Arthritis, Asthma, Difficulty Breathing, Emphysema, Fainting, Fever Blisters, Recurrent Infections, Rheumatism, Shingles, Sinus Problems, Ulcers, Venereal Disease, Weight Change?
Have you had braces before? Yes / No
Are you in braces now? Yes / No

By signing here, I confirm that the information that I have given today is correct to the best of my knowledge. Please, don't forget your regular dental check-ups with your family dentist.

_____ _____
Signature (patient/guardian) Date

Please print your name _____

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INFORMED CONSENT

PLEASE READ CAREFULLY

THE ADVANTAGES AND DISADVANTAGES OF TREATMENT, THE ALTERNATE APPROACHES TO TREATMENT, THE TYPES OF APPLIANCES AND THEIR EFFECTS WERE DISCUSSED AND UNDERSTOOD. POTENTIAL RISKS AND COMPLICATIONS FROM BRACES WERE EXPLAINED AND UNDERSTOOD. These may include, but are not limited to, cavities and inflammation of gums due to poor oral hygiene, root canal therapy on weak, injured or restored teeth, root resorption due to treatment or unknown reasons, joint (TMJ) problems due to existing conditions, or trauma. Impacted or ankylosed teeth or other conditions of teeth may compromise result. You understand that, while the expected results of treatment have been explained to you, such expectations cannot be guaranteed, as they can be influenced by various known or unknown reasons. The length of treatment is not exact, as different people may present with different problems. General health problems such as bone, blood or endocrine disorders, and many prescription and non-prescription drugs (including bisphosphonates) can affect your orthodontic treatment.

OUR OFFICES ARE NOT OPEN EVERY DAY; IF AN EMERGENCY HAPPENS WHEN THE OFFICE IS CLOSED, OR ON THE WEEKEND OR ON A HOLIDAY AND YOU CANNOT REACH US WITHIN 5-15
MINUTES, WE RECOMMEND YOU GO TO THE NEAREST EMERGENCY ROOM.

A LOOSE BRACKET/S, ARE NOT DEEMED AS AN EMERGENCY. PLEASE WAIT UNTIL YOUR NEXT SCHEDULED APPOINTMENT TO RECTIFY THIS.

BE AWARE THAT CERAMIC BRACKETS WILL DEBOND ON A MORE REGULAR BASIS THAN METAL BRACKETS. YOU WILL HAVE TO TAKE EXTRA CARE TO PREVENT THIS FROM HAPPENING.

IF AN ALLERGIC REACTION OCCURS, IMMEDIATELY GO TO THE NEAREST EMERGENCY ROOM. ORTHODONTIC BRACES ARE MADE FROM STAINLESS STEEL. STAINLESS STEEL CONTAINS
NICKEL AND CHROMIUM. PLEASE, CONTACT A PHYSICIAN TO SEE IF YOU ARE ALLERGIC TO ANY OF THE ABOVE. IT IS THE PATIENT'S RESPONSIBILITY TO INFORM THE OFFICE OF ANY CHANGES IN THE PATIENT'S HEALTH OR MEDICATIONS (PRESCRIBED OR NON-PRESCRIBED) FROM VISIT TO VISIT.

TREATMENT AT EACH LOCATION IS PERFORMED BY GENERAL DENTISTS AND CLINICAL STAFF.

You hereby authorise us to see your child(ren) in your absence; otherwise, you will be with your child(ren) in the treatment room. The patient must continue to see his/her dentist every 3-6 months during treatment for dental-check-ups. Please, follow your dentist's (or oral surgeon's) recommendation regarding your wisdom teeth.

Loose or broken braces/expander(s) that do not cause discomfort may be fixed at your regular appointment. We recommend wearing an orthodontic mouth guard when playing sports. It is understood that the patient is not pregnant and that the patient does not need to be pre- medicated

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for any dental procedures, orthodontic adjustments of the braces or any accidental bleeding of the mouth. If you still have braces/expander(s) on your teeth and you do not want to

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continue with treatment, we invite you to come in to have them removed. Leaving braces/expander(s) on the teeth without proper oral hygiene and attendance by a doctor of your choice would cause ramifications (decalcification of tooth enamel, gum inflammation, tooth deterioration, etc.) more adverse than would occur if the braces were removed. When you want to start again, a new fee will apply.

Risks summary

1. Decay and decalcification due to oral hygiene non-compliance
2. Root resorption
3. Inflammation, periodontal problems due to oral hygiene non-compliance
4. Relapse (teeth shift) due to retainer wear non-complaince
5. Temporomandibular joint pain, headaches, ear problems
6. Need for root canal treatment
7. Gum, soft tissue irritation, swallowed or aspirated appliance
8. Scratched or poke to soft tissue or gums or blow to the tooth. Abnormal tooth wear.
9. Injuries to the face and eyes
10. Risks for surgery and anaesthesia
11. Inability to achieve desired results
12. Extended length of time to complete treatment
13. Enamel fracture or flaking
14. Spacing
15. Changes in medical history

SIGNATUR_____ DATE_____
E

Join the Fastbraces® online community! Please "like" us in Facebook! We would like to stay in touch with you and address any questions or concerns you may have in the years to come.

Like us on Facebook

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ORTHODONTIC TREATMENT PLAN AGREEMENT

FOR · PHASE I (EXPANDERS) AND/OR · PHASE II (BRACES AND RETAINERS)

ESTIMATED DAYS IN TREATMENT: □90 □120 □180 □270 □>270

Treatment time varies based on the patient's individual bone, teeth, hygiene and cooperation (the results are affected from the above also). In the event that treatment finishes earlier or later that the anticipated time quoted, no change to the fee will be applied.

If only one jaw to be treated, deduct £400 off the estimate (EXCLUDES re-treatments).

- o FASTBRACES® CLASSIC METAL £2, 900

- o FASTBRACES® TURBO ™
- o Up to 120 Days £3, 200
- o Up to 180 Days £3, 500
- o Up to 270 Days £3, 700
- o More than 270 Days £3, 900

- o Ceramic Brackets Add £250/Arch

Your re-treatment/treatment started elsewhere will cost you from £900.00

ADDITIONAL fee for expander is £500.00 per expander. You will need 1 / 2

Payment Plan:

· Full payment received BEFORE your records appointment, 10% discount – NON NEGOTIALBE and based on conditions set out above

Or

· Deposit of £500 + £_____.___ per month for ____ months; MAXIMUM OF 12 MONTHS. (Payment term based on your estimated treatment time.)

YOUR BRACKETS WILL ONLY BE REMOVED ONCE THE ACCOUNT HAS BEEN CLEARED IN FULL.
Treatment estimates valid for 30 only.

You will be entitled to either a free hygienist visit or a home teeth whitening kit if you are prepared to do a positive video testimonial after your treatment, talking about your treatment experience and outcome. You may also do a

Facebook testimonial during and after your treatment. We would like to use this for promotional purposes.

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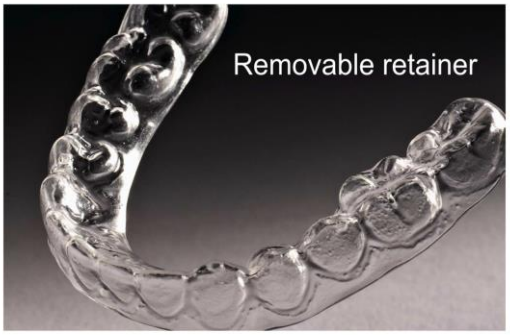
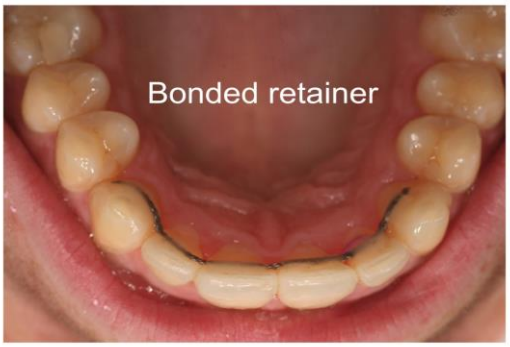
Please tick this box if you are happy to do this… •





ALL CASES REQUIRE A RETENTION PROGRAMME AFTER TREATMENT

RETENTION IS FOR LIFE

WE ALWAYS ADVISE A BONDED LINGUAL RETAINER AS A MINIMUM

RETAINERS: Your investment has to be secured with retainers after treatment. Your treatment cost will include the fitting of bonded retainers OR removable OR a combination of one of each type of retainers. There are NO permanent retainers and they may need replacement or require re-bonding. You will have to pay fees associated to appointments and/or replacement of retainers.

TREATMENT PLAN: Treatment rendered is your choice. You have been informed of the treatment options that may apply to you (treatment/non-extraction/extraction/surgery) and prognosis, benefits and risks of each and you consented to the treatment and refused other options.

AS PER OUR DISCUSSION, ALL OR SOME APPLY TO YOUR CASE:

What we will do for you: align the crooked teeth or reduce the spaces, improve the cross-bite (if child treatment), reduce the overbite or open bite.

What may remain after treatment: some crowding, rotations, spacing or cross-bite, some overbite or open bite or midline deviation, some opening above gum line or need for dental cosmetics.

What you need to check with your dentist or physician: dental and periodontal check-up before we put braces, cosmetic dentistry for the shape or size of some teeth, crown lengthening/grafts for the level of your gums, wisdom teeth (if present), eruption of permanent teeth (if mixed dentition), TMJ evaluation (if pain or lock or other symptoms), medical evaluation/clearance, other____ _____.

Signature of Patient or Legal Guardian _____ Print Name of Legal Guardian _____ Date

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Print Name of Patient

ADDITIONAL FINANCIAL: I have read, understood, and agreed to all terms listed on this document and I authorise IGDP Limited to automatically withdraw from the credit or debit card(s) listed, the monthly payment on the 1st of each month (or as described agreed). If any payment doesn't clear by the 3rd day from the scheduled day or any payment to our office is disputed unnecessarily, a £30 charge will be automatically added to the balance. IGDP Limited reserves the right to cancel the financial agreement in the event that you do not keep to the terms of payment. Full payment will then be due before treatment will continue. No extension of credit is given. Insurance coverage is between you and your employer. We will prepare the paperwork for you. We recommend you send it to your insurance via Recorded Delivery. Please tell your insurance to pay you.

The cost of the records of orthodontic radiographs and orthodontic photographs is £200. The cost of orthodontic moulds is £25 for a set. The cost of one set of clear retainers after treatment is £200. All of the above are included in your fee. The fee does not include any charges at your dentist or emergency room. A £300 charge will be applied immediately when the braces are removed temporarily (i.e. wedding, etc.) A £300 charge will be applied immediately if you transfer to a different doctor affiliated with Fastbraces.

THE RECORDS FEE IS NON-REFUNDABLE. IN ADDITION, A £250 CANCELLATION FEE WILL BE APPLIED (WHICH INCLUDES THE TREATMENT PLAN AND RADIOGRAPHIC ANALYSIS DONE BY THE DOCTOR).

Credit/Debit Card Number_____

Expiry Date_____

Please inform your bank that payments will be taken from this account

Also required:
Backup Card Number_____

Expiry Date_____

Please inform your bank that payments will be taken from this account

BACS payments
Account Number: 10097919
Sort Code: 16-21-29
Reference: _____

Patients opting for staged payments will be required to provide the following:

Identification

- Passport OR
- Driver's License AND
- Proof of address, e.g. Utility Bill, e.g. electricity/gas/water/council tax bill

UK DATA PROTECTION ACT

PLEASE READ CAREFULLY
You understand that, as part of the provision of healthcare services, the doctor creates and maintains health records and other information describing among other things, your health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

You have been provided with a notice of privacy practices (available on our web site: igdp.co.uk) that provides a more complete description of the uses and disclosures of certain health information. You understand that you have the right to review the notice prior to signing this consent. You understand that the doctor reserves the right to change his/her notice and practices and prior to implementation will mail a copy of any revised notice to the address you have provided. You understand that you have the right to object to the use of your health information for directory purposes.

You understand that you have the right to request restrictions as to how your health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the doctor is not required to agree to the restrictions requested. By signing this form, you consent to the use and disclosure of protected health information about the patient for the purposes of treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where disclosures have already made in reliance on your prior consent.

This consent is given freely with the understanding that: a) Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without your prior written authorisation, except as otherwise provided by law b) a photocopy or fax of this consent is as valid as this original c) You have the right to request that the use of your Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations be restricted. You also understand that the doctor and you must agree to any restriction in writing that you request on the use and disclosure of your protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of your protected health information, which have been previously agreed upon.

SIGNATURE _____ DATE_____