Center for Orthodontics

Consent for Initial Exam and Records

Consent for Initial Exam and Records:
I hereby consent to Seton Hill University Center for Orthodontics, its faculty, residents, and staff when appropriate to perform an initial orthodontic examination, making of diagnostic records, including x-rays, so that orthodontic treatment may be considered for me (my minor child).

Authorization for Release of Patient Information:
I hereby authorize Seton Hill University Center for Orthodontics to provide other health care providers with information regarding the above individual's orthodontic care as deemed appropriate. I understand that once released, Seton Hill University Center for Orthodontics has no responsibility for any further release by the individual receiving this inforrmation.

Acknowledgment:
I hereby acknowledge that I have read and fully understand this consent form. I hereby consent to an initial orthodontic examination, and orthodontic diagnostic records. I also authorize Seton Hill Center for Orthodontics, its faculty, residents and staff to provide my health care information to my other health care providers. I understand that Seton Hill University Center for Orthodontics is a graduate teaching program in orthodontics and although the best orthodontic care will be provided for you (your child), this treatment is provided by resident doctors under the direct supervision of faculty orthodontists.

Patient's Name: ✱

Characters: (500 max.)

Electronic Signature of Patient/ Parent/ Legal Guardian: ✱

Characters: (500 max.)

Relationship to Patient if minor child: ✱

Characters: (500 max.)

Patient Address ✱

Characters: (500 max.)

Patient Date of Birth ✱

Characters: (500 max.)

Phone Number : Cell & Home

Characters: (500 max.)

MEDICAL RECORDS RELEASE

I Authorize Seton Hill University, custodian of my Protected Health Information / Medical Records to disclose/release the following information* (check all that apply) from my Center for Orthodontic Record if necessary:

- ☐ All treatment records
- ☐ Xray/radiology records
- ☐ Billing Records or Insurance Records
- ☐ Orthodontic diagnostic aids/models

Please send the records listed above to : Provide the following information: (ie. your dentist) Name Address Phone Fax / Email

Characters: (500 max.)

The information may be used or disclosed for each of the following purposes:

○ At my request (only the patient can check this box and there is a charge for the records)

○ For my continued health care or for additional medical/dental evaluation or opinion

○ For payment/insurance/financial purposes ○ For employment, military or school purposes Clear

These records are for services provided on the following dates:

Characters: (500 max.)

This authorization shall expire no later than:______________ .And may not be valid for greater than six months from the date of the signature for this Pennsylvania dental/medical record. I understand that after Seton HIll University discloses my requested health information,it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refuasal to sign will not affect my ability to obtain treatment: recieve payment :or eligbility for benefits unless allowed by law. By Signing below I represent and warrant that I have the authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information ---- Please provide digital signature in the column to the right.

Characters: (500 max.)

INITIAL SELF ASSESSMENT

Please rate the follwoing characteristics on a scale from 1 to 5
1 = least satisfactory 3 = Neutral 5 = most satisfactory

How straight my (child's) teeth are now:

My (child's) bite now:

My (child's) profile now:

My (child's) smile now:

Your (child's) overall facial appearance now:

MARKETING RELEASE
(This is voluntary)

Date:

mm/dd/yyyy

I hereby grant Seton Hill University & The Center for Orthodontics permission to use, reuse, publish and republish photographic portraits and video likenesses of me, pictures or video in which I or my child (minor) may be included, audio or video recordings I create or representations of my artwork in university publications and in any and all media (including web site or Internet) now or here-after, known for illustration, promotion, art, or advertising of Seton Hill University. By giving my email, I hereby allow SHU Center for Orthodontics to contact me electronically.
I hereby warrant that I am either of full age, or I am the parent/ guardian of the minor, and have the right to contract my own or my childs name. I have read the above authorization, release, and agreement.

Patient Name:

Characters: (500 max.)

Parent/ Guardian Electronic Signature:

Characters: (500 max.)

HIPPA FOR NEW PATIENTS

Patient Acknowledgement of the Notice of Privacy Practices

You may view the Notice of Privacy Practices in our office in person. Or, you can contact us & we can email these to you if you would like to review. I acknowledge that I have been offered or received the copy of the Seton Hill University Center for Orthodontics Notice of Privacy Practices, for my protection, as required by law. Patient or Parent/ Guardian Electronic Signature:

Characters: (500 max.)

SHU CENTER FOR ORTHODONTICS OFFICE DOCUMENTATION USE ONLY. No signature obtained due to one of the following: -Individual refusedl to sign the acknowledgement of the Notice of Privacy Practices. - Communication barriers prohibited obtaining the acknowledgment. -An emergency situation prevented us from obtaining acknowledgement. -Other If no patient or parent/ guardian signature acquired, SHU representative please sign & date.

PATIENT SCREENING FORM

Patient Name:

Characters: (500 max.)

PLEASE COMPLETE THIS COVID-19 DOCUMENT! IF YOU HAVE RECENTLY TRAVELED, the PA Department of Health has identified hot states & is recommending 14 day quarantine after returning & we are abiding by those recommendations.

Characters: (500 max.)

Are you/ they having shortness of breath or other difficulites breathing? *

- ☐ Yes
- ☐ No

Are you/they in contact with any confirmed COVID-19 positive patients? Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment. *

- ☐ Yes
- ☐ No

Do you/they have a cough? Any flu-like symptoms, such as sore throat, gastrointestinal upset, headache, or fatigue? *

- ☐ Yes
- ☐ No

Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)? *

- ☐ Yes
- ☐ No

Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune issues? *

- ☐ Yes
- ☐ No

Have you/they experienced recent loss of taste or smell? *

☐ Yes

☐ No

Is anyone at hone experiencing any of the above symptoms? ✱

☐ Yes

☐ No

Is your/their age over 60? ✱

☐ Yes

☐ No

Have you/they traveled in the past 14 days to any regions affected by COVID-19? As of 7/27/2020 those include Alabama, Arizona, Arkansas, California, Delaware, Florida, Georgia, Idaho, Iowa, Kansas, Louisiana, Mississippi, Missouri, Nevada, North Carolina, Oklahoma, South Carolina, Tennessee, Texas and Utah & Wyoming. ✱

☐ Yes

☐ No

Positive responses to any of these above questions would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment. If you have traveled to a 'hot spot', please self-quarantine for 14 days prior to coming into the clinic.

*** For testing, see the list of State and Territorial Health Department Websites for your specific area's information.**

American Association of Orthodontists
Medical Dental History Form for Patients

For the following questions mark Yes, No, or Don't Know/Understand (DK/U). The answers are for office records only and will be
considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

Patient's Last Name:

Characters: (500 max.)

Patient's First Name:

Characters: (500 max.)

Patient's Middle Name/ Initial:

Characters: (500 max.)

Birth Date:

mm/dd/yyyy

Age:

Characters: (500 max.)

Sex:

○ Male ○ Female Clear

Prefers to be Called:

Characters: (500 max.)

S.S.N. /S.I.N.:

Characters: (500 max.)

Email Address

Characters: (500 max.)

Cell Phone

Characters: (500 max.)

Home Phone No.:

Characters: (500 max.)

Patient's Address:

Characters: (500 max.)

City:

Characters: (500 max.)

State/ Province:

Characters: (500 max.)

Zip/ Postal Code:

Characters: (500 max.)

FOR SCHOOL STUDENTS IF APPLICABLE

Attends School At:(If Applicable)

Characters: (500 max.)

Grade:

Characters: (500 max.)

Musical Instruments Played:

Characters: (500 max.)

Sports And/Or Hobbies:

Characters: (500 max.)

No. of brothers and sisters:

Characters: (500 max.)

Other family members treated here:

Characters: (500 max.)

Mother's Information (IF PATIENT IS UNDER THE AGE OF 18)

Last Name:

Characters: (500 max.)

First Name:

Characters: (500 max.)

Address (if different than patient's):

Characters: (500 max.)

City:

Characters: (500 max.)

State/ Province:

Characters: (500 max.)

Zip/ Postal Code:

Characters: (500 max.)

Home Phone No. (if different than patient's):

Characters: (500 max.)

Work:

Characters: (500 max.)

Cell Phone/ Pager:

Characters: (500 max.)

Email address:

Characters: (500 max.)

Mother's Marital Status:

- ☐ Single
- ☐ Married
- ☐ Widowed
- ☐ Divorced
- ☐ Other

Father's Information (IF PATIENT IS UNDER THE AGE OF 18)

Last Name:

Characters: (500 max.)

First Name:

Characters: (500 max.)

Address (if different than patient's):

Characters: (500 max.)

City:

Characters: (500 max.)

State/ Province:

Characters: (500 max.)

Zip/ Postal Code:

Characters: (500 max.)

Home phone number (if different than patient's):

Characters: (500 max.)

Work:

Characters: (500 max.)

Cell Phone/ Pager:

Characters: (500 max.)

Email Address:

Characters: (500 max.)

Father's Marital Status:

- ☐ Single
- ☐ Married
- ☐ Widowed
- ☐ Divorced
- ☐ Other

Dental Provider Information

Name Of Patient's Dentist: ✱

Characters: (500 max.)

Phone No.:

Characters: (500 max.)

Dentist's Address:

Characters: (500 max.)

City:

Characters: (500 max.)

State/ Province:

Characters: (500 max.)

Zip/ Postal Code:

Characters: (500 max.)

Date Last Seen:

mm/dd/yyyy

Reason:

Characters: (500 max.)

Primary Care Physician Information

Name Of Patient's Physician (s):

Characters: (500 max.)

Phone No(s).:

Characters: (500 max.)

Physician's Address:

Characters: (500 max.)

City:

Characters: (500 max.)

State/ Province:

Characters: (500 max.)

Zip/ Postal Code:

Characters: (500 max.)

Date Last Seen:

mm/dd/yyyy

Reason:

Characters: (500 max.)

Who Is Financially Responsible For This Account?

Last Name:

Characters: (500 max.)

First Name:

Characters: (500 max.)

Middle Name/Initial:

Characters: (500 max.)

Address (if different from patient's):

Characters: (500 max.)

City:

Characters: (500 max.)

State:

Characters: (500 max.)

Zip:

Characters: (500 max.)

Phone No. (if different than patient's):

Characters: (500 max.)

S.S.N/S.I.N .:

Characters: (500 max.)

Employer:

Characters: (500 max.)

Insurance Coverage For Dental Treatment?

○ Yes ○ No Clear

Insurance Coverage For Orthodontic Treatment?

○ Yes ○ No Clear

DENTAL INSURANCE COMPANY:

Characters: (500 max.)

INSURANCE ID#:

Characters: (500 max.)

Primary Policy Holder's Name:

Characters: (500 max.)

S.S.N./S.I.N. of Insurance Holder:

Characters: (500 max.)

Birth Date of insurance holder:

mm/dd/yyyy

Employed By:

Characters: (500 max.)

Secondary Policy Holder's Name:

Characters: (500 max.)

Dental Insurance Company:

Characters: (500 max.)

INSURANCE ID#:

Characters: (500 max.)

S.S.N./S.I.N.:

Characters: (500 max.)

Birth Date:

mm/dd/yyyy

Employed By:

Characters: (500 max.)

Medical Insurance Company:

Characters: (500 max.)

Group No.:

Characters: (500 max.)

Who suggested that you/ your child might need orthodontic treatment?

Characters: (500 max.)

Why did you select our office?

Characters: (500 max.)

Patient Profile

Does patient follow directions well? ✱

○ Yes ○ No ○ DK/U Clear

Does patient brush his / her teeth conscientiously? ✱

○ Yes ○ No ○ DK/U Clear

Does the patient have learning disabilites or need extra help with instructions? ✱

○ Yes ○ No Clear

Is patient sensitive or self-conscious about teeth? ✱

○ Yes ○ No Clear

Now or in the past, has the patient had:

Birth defects or hereditary problems? ✱

○ Yes ○ No ○ DK/U Clear

Bone fractures, any major accidents? ✱

○ Yes ○ No Clear

Rheumatoid or arthritic conditions? ✱

○ Yes ○ No Clear

Endocrine or thyroid problems? ✱

○ Yes ○ No Clear

Kidney Problems?

○ Yes ○ No ○ DK/U Clear

Diabetes? ✱

○ Yes ○ No ○ DK/U Clear

Cancer, tumor, radiation treatment or chemotherapy? ✱

○ Yes ○ No ○ DK/U Clear

Has your child ever taken intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidrontate) or Didronel (etidrontate) for bone disorders or cancer?

○ Yes ○ No ○ DK/U Clear

Has your child ever taken oral bisphosphonates such as Fosomax (aiendronate), Acetonel (ridendronate), Boniva (ibandrinate), Skelid (tiludronic) or Didrinel (eitdronate) for bone disorders?

○ Yes ○ No ○ DK/U Clear

History of Osteoprosis

○ Yes ○ No ○ DK/U Clear

Stomach ulcer or hyperacidity? ✱

○ Yes ○ No ○ DK/U Clear

Polio, mononucleosis, tuberculosis or pneumonia?

○ Yes ○ No ○ DK/U Clear

Problems of the immune system?

○ Yes ○ No ○ DK/U Clear

AIDS or HIV positive?

○ Yes ○ No ○ DK/U Clear

Hepatitis, jaundice or liver problems?

○ Yes ○ No ○ DK/U Clear

Mental health disturbance or behavioral problems?

○ Yes ○ No ○ DK/U Clear

Vision, hearing, tasting or speech difficulties?

○ Yes ○ No ○ DK/U Clear

Loss of weight recently, poor appetite?

○ Yes ○ No ○ DK/U Clear

History of eating disorder (anorexia, bulimia)?

○ Yes ○ No ○ DK/U Clear

Excessive bleeding or bruising tendency, anemia or bleeding disorder?

○ Yes ○ No ○ DK/U Clear

High or low blood pressure?

○ Yes ○ No ○ DK/U Clear

Seizures, fainting spells, neurological problems ?

○ Yes ○ No ○ DK/U Clear

Chest pain, shortness of breath or swelling ankles?

○ Yes ○ No ○ DK/U Clear

Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?

○ Yes ○ No ○ DK/U Clear

Skin disorder?

○ Yes ○ No ○ DK/U Clear

Does the patient eat a well-balanced diet?

○ Yes ○ No ○ DK/U Clear

Frequent headaches, colds or sore throats?

○ Yes ○ No ○ DK/U Clear

Hayfever, asthma, sinus trouble or hives?

○ Yes ○ No ○ DK/U Clear

Tonsil or adenoid conditions?

○ Yes ○ No ○ DK/U Clear

Is the patient taking medication, nutrient supplements, herbal medications or non-prescription medicine?

○ Yes, please name them{} ○ No ○ DK/U Clear

Does the patient currently have or ever had a substance abuse problem? ✱

○ Yes ○ No ○ DK/U Clear

Does the patient chew or smoke tobacco? ✱

○ Yes ○ No ○ DK/U Clear

Operations?

○ Yes, Describe:{} ○ No ○ DK/U Clear

Hospitalized?

○ Yes, For{} ○ No ○ DK/U Clear

Other physical problems or symptoms?

○ Yes, Describe:{} ○ No ○ DK/U Clear

Being treated by another health care professional?

○ Yes, For{} ○ No ○ DK/U Clear

Date of last physical exam?

mm/dd/yyyy

Are there any other medical conditions that we should be aware of?

Characters: (500 max.)

Have you ever been told by your Doctor that you need to be pre-medicated before any dental treatments?

○ Yes ○ No ○ DK/U Clear

Females Only

Has the patient started her monthly periods? (IF UNDER THE AGE OF 18)

○ Yes, For{} ○ No ○ DK/U Clear

Is the patient pregant?

○ Yes ○ No ○ DK/U Clear

Allergies or reactions to any of the following:

Local anesthetics (Novocaine or Lidocaine)

○ Yes ○ No ○ DK/U Clear

Aspirin

○ Yes ○ No ○ DK/U Clear

Ibuprofen (Motrin, Advil)

○ Yes ○ No ○ DK/U Clear

Penicillin or other antibiotics

○ Yes ○ No ○ DK/U Clear

Sulfa Drugs

○ Yes ○ No ○ DK/U Clear

Codeine or other narcotics

○ Yes ○ No ○ DK/U Clear

Metals (jewelry, clothing snaps)

○ Yes ○ No ○ DK/U Clear

Latex (gloves, balloons)

○ Yes ○ No ○ DK/U Clear

Animals

○ Yes ○ No ○ DK/U Clear

Foods

○ Yes (specify){} ○ No ○ DK/U Clear

Other Substances

○ Yes (specify){} ○ No ○ DK/U Clear

Family Medical History

Does the patient's parents or siblings have any of the following health problems? If so, please explain.

- ☐ Bleeding Disorders{}
- ☐ Diabetes{}
- ☐ Arthritis{}
- ☐ Metabolic Disturbances{}
- ☐ Severe Allergies{}
- ☐ Unusual Dental Problems{}
- ☐ Jaw Size Imbalance{}
- ☐ Any other family medical conditions that we should know about?{}

Dental History

Now or in the past, has the patient had:

Permanent or "extra" (supernumerary) teeth removed?

○ Yes ○ No ○ DK/U Clear

Primary (baby) teeth removed that were not loose?

○ Yes ○ No ○ DK/U Clear

Started teething very early or late?

○ Yes ○ No ○ DK/U Clear

Chipped or otherwise injured primary (baby) or permanent teeth?

○ Yes ○ No ○ DK/U Clear

Teeth sensitive to hot or cold; teeth throb or ache?

○ Yes ○ No ○ DK/U Clear

Jaw fractures, cysts or mouth infections?

○ Yes ○ No ○ DK/U Clear

"Dead teeth" or root canals treated?

○ Yes ○ No ○ DK/U Clear

Bleeding gums, bad taste or mouth odor?

○ Yes ○ No ○ DK/U Clear

Periodontal "gum problems"?

○ Yes ○ No ○ DK/U Clear

Food impaction between teeth?

○ Yes ○ No ○ DK/U Clear

"Gum Boils", frequent canker sores or cold sores?

○ Yes ○ No ○ DK/U Clear

Thumb, finger or sucking habit? If yes, until what age?

○ Yes{} ○ No ○ DK/U Clear

Abnormal swallowing habit (tongue thrusting?)

○ Yes ○ No ○ DK/U Clear

History of speech problems?

○ Yes ○ No ○ DK/U Clear

Mouth breathing habit, snoring or difficulty in breathing?

○ Yes ○ No ○ DK/U Clear

Tooth grinding or jaw clenching?

○ Yes ○ No ○ DK/U Clear

Any pain, clicking or locking in jaw or ringing in the ears?

○ Yes ○ No ○ DK/U Clear

Any pain or soreness in the muscles of the face or around the ears?

○ Yes ○ No ○ DK/U Clear

Difficulty in chewing or jaw opening?

○ Yes ○ No ○ DK/U Clear

Aware of loose, broken or missing restorations (fillings)?

○ Yes ○ No ○ DK/U Clear

Any teeth irritating cheek, lip, tongue or palate?

○ Yes ○ No ○ DK/U Clear

Concerned about spaced, crooked or protruding teeth?

○ Yes ○ No ○ DK/U Clear

Aware or concerned about under or over developed jaw?

○ Yes ○ No ○ DK/U Clear

Any relative with similar tooth or jaw relationships?

○ Yes ○ No ○ DK/U Clear

Any wisdom tooth problems?

○ Yes ○ No ○ DK/U Clear

Had periodontal (gum) treatment?

○ Yes ○ No ○ DK/U Clear

Had any serious trouble associated with any previous dental treatment?

○ Yes ○ No ○ DK/U Clear

Been under another dentist's care?

○ Yes, Specialist{}Other{} ○ No ○ DK/U Clear

Ever had a prior orthodontic examination?

○ Yes ○ No ○ DK/U Clear

Would patient object to wearing orthodontic appliances (braces) should they be indicated?

○ Yes ○ No ○ DK/U Clear

How often do you/ your child brush?

☐ Daily

☐ Weekly

☐ Occasionally

☐ DK/U

What are your primary concerns?

Characters: (500 max.)

RELEASE AND WAIVER

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my child's medical or dental health. I authorize release of any information regarding myself or child's orthodontic treatment to my dental/medical Insurance company. * ELECTRONIC SIGNATURE REQUIRED ✱

Characters: (500 max.)

SHU Resident/ Dr. electronic signature