WELCOME to Seton Hill University Center for Orthodontics!

A Winning Smile isn't everything, it's the only thing!

- Options: Traditional Braces, Ceramic Braces & Invisalign
  We are a "Gold Invisalign" provider!
- Affordability: 5% discount if paid in advance OR affordable monthly payments with no interest or fees.
- Straight Teeth: *When is it your turn?*

We are Orthodontic Specialists, it's all we do!

Seton Hill
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Center for Orthodontics

Patient / Doctor Assignment

The scheduling of our patients is based on the classification of the patient and the needs of each resident doctor's case load. Since we are a teaching institution our resident doctors are required to have a certain number of each case type in order to experience the full scope of orthodontics.

You may receive an appointment before you leave your initial exam. However, depending on the classification of your case, you may be assigned to another first year resident doctor **and/or** need to reschedule your consultation and the start of your treatment. Depending on the length of your orthodontic treatment, this should be the only time that you will experience a change in your assigned resident doctor. As our resident doctors near the end of their training, if your treatment time is protracted, you will be assigned to their co-resident doctor to finish your treatment.

Thank you for your flexibility and understanding as we continue to provide the highest level of evidence based treatment for our patients while providing our resident doctors with an education that is second to none.

Sincerely,

Dr. Daniel Rinchuse,

Professor and Program Director

Seton Hill University Center for Orthodontics

Seton Hill
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Seton Hill University Center for Orthodontics
2900 Seminary Drive Building E
Greensburg, PA 15601
724-552-2950

CONSENT FOR INITIAL EXAM AND RECORDS

Patient's Name: _____

CONSENT FOR INITIAL EXAMINATION 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 information.

ACKNOWLEDGEMENT

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.*

ADDITIONAL NOTES: _____

_____

I have the legal authority (if a minor child) to sign this on behalf of

Name of Patient: _____

Signature of Patient/parent/legal guardian _____ Date _____

Relationship to Patient if minor child _____

Witness _____ Date _____

Initial release

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Payment Options

Payment in Full
A courtesy of 5% is acknowledged for direct payment in full by cash, check or credit card at the start of treatment.

Office Payment Plan
Our in-office payment plan is 100% interest free. The balance may be paid through 20 monthly payments and the contract will start during the financial consultation. We require a credit card/debit card to be stored on site. We will bill the said card every month between the first and the fifth. Patients utilizing flex spending accounts may make special arrangements if necessary.

If you have State insurance, we require a valid credit/debit card be kept on file in case the State declines to pay. This is relevant for all patients with PPO/HMO insurance as well. A valid credit/debit card must be kept on file during the time you or a child is a patient in our office.

A $25.00 late fee will be charged if payment is past due. A $35.00 charge for insufficient funds will appear on your ledger if relevant. Failure to regular monthly payments will result in your account being sent to our collection agency and additional fees and charges.

If you have any questions related to this information, please do not hesitate to call Kelli Wege at 724-552-2950. We will collect your credit/debit card information at the financial consultation.

Signature: _____

Email Address: _____

By giving my email, I hereby allow SHU Center for Orthodontics to contact me electronically.

Date: _____

ATTACHMENT: Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information by printing legibly:

Patient Name: _____ Date of Birth: ____/____/____

Address: _____

_____

Phone(s): Home: _____ Cell: _____

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:

___ All treatment records

___ X-ray/radiology records: _____

___ Billing records or Insurance records

___ Orthodontic diagnostic aids /models

___ Other (describe specifically) _____

**Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

These records are for services provided on the following date(s): _____

Please send the records listed above to (use additional forms if necessary):

1) Name: _____
Address: _____
_____
Phone: _____
Fax or email: _____

2) Name: _____
Address: _____
_____
Phone: _____
Fax or email: _____

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
___ Other (detail): _____

This authorization shall expire no later than: ____/____/____ or upon the following event: _____(whichever is sooner), and may not be valid for greater than six month from the date of 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 refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have 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.

_____ _____

Signature of Patient (or Patient's Personal Representative) Date

_____ _____

Printed name of Patient Representative ** Representative's Relationship to Patient

SETON HILL UNIVERSITY CENTER FOR ORTHODONTICS

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT:

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 Personal Representative Signature** **Date**

If Personal Representative signs above for the patient, specify relationship: _____ **(*Right to Refuse)**

SETON HILL UNIVERSITY CENTER FOR ORTHODONTICS

CENTER FOR ORTHODOTNICS --OFFICE DOCUMENTATION USE ONLY

PATIENT "REFUSAL TO SIGN" THE PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES

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

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

SHU Representative / Witness Signature: _____

Date: _____

American Association of Orthodontists
My Life. My Smile. My Orthodontist.®

Medical Dental History Form for Adult Patients

CONFIDENTIAL

PATIENT

Date _____

Patient's last name _____ First name _____ Middle initial _____

Title Mr. Mrs. Ms. Miss. Dr. Other _____ I prefer to be called _____

Birth date _____ Sex ☐ Male ☐ Female Social Security # _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home address _____ City, State, Zip code _____

Home phone ( ) _____-_____ Cell phone ( ) _____-_____ Work phone ( ) _____-_____

Email Address(es) _____

Occupation _____ Employer _____

CLOSEST RELATIVE

Spouse or closest relatives name(s) _____

Title Mr. Mrs. Ms. Miss. Dr. Other _____ Relationship to patient _____

Address *(if different than patient address)* _____

Home Phone *(if different)* ( ) _____-_____ Cell phone ( ) _____-_____ Work phone ( ) _____-_____

DENTIST

Patient's Dentist _____ Address, City, State _____

Last seen _____ Reason _____ Next appointment _____

Other dentists/dental specialists now being seen: Name _____ City, State _____

Reason _____

PHYSICIAN

Patient's Physician _____ City, State _____

Last seen _____ Reason _____ Next appointment _____

Most recent physical exam _____

Other physicians/health care providers being seen now:

Name _____ City, State _____

Reason _____

Name _____ City, State _____

Reason _____

General Information

What concerns you about your teeth? _____

Who suggested that you might need orthodontic treatment? _____

Why did you select our office? _____

Have you had any previous orthodontic treatment? Please describe. _____

Have any other family members been treated in this office? Please name them. _____

Do you think that any of your work or leisure activities affect your teeth or jaws? Please explain. _____

_____

Financial Responsibility

Who is financially responsible for this account? _____

Address *(if different than page 1)* _____ City, State, Zip _____

Home phone ( ) - Cell phone ( ) - Email address(es) _____

Social Security # _____ Employer _____

Dental Insurance

Primary policy holder's full name _____ Birth date _____

Social Security # _____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID# _____

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know

Secondary policy holder's full name _____ Birth date _____

Social Security # _____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID# _____

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know

Medical Insurance

Policy holder's full name _____

Insurance Company _____

Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation.

For the following questions, please mark yes, no, or don't know/understand (dk/u).

Medical History

Now or in the past, have you had:

Yes No DK/U

- ☐ ☐ ☐ Birth defects or hereditary problems?
- ☐ ☐ ☐ Bone fractures or major injuries?
- ☐ ☐ ☐ Any injuries to face, head, neck?
- ☐ ☐ ☐ Arthritis or joint problems?
- ☐ ☐ ☐ Endocrine or thyroid problems?
- ☐ ☐ ☐ Diabetes or low sugar?
- ☐ ☐ ☐ Kidney problems?
- ☐ ☐ ☐ Cancer, tumor, radiation treatment or chemotherapy?
- ☐ ☐ ☐ Stomach ulcer, hyperacidity, acid reflux?
- ☐ ☐ ☐ Immune system problems?
- ☐ ☐ ☐ History of osteoporosis?
- ☐ ☐ ☐ Gonorrhea, syphilis, herpes, sexually transmitted diseases?
- ☐ ☐ ☐ AIDS or HIV positive?
- ☐ ☐ ☐ Hepatitis, jaundice, or other liver problems?
- ☐ ☐ ☐ Polio, mononucleosis, tuberculosis, pneumonia?
- ☐ ☐ ☐ Seizures, fainting spells, neurologic problems?
- ☐ ☐ ☐ Mental health disturbance or depression?
- ☐ ☐ ☐ Vision, hearing, or speech problems?
- ☐ ☐ ☐ History of eating disorder (anorexia, bulimia)?
- ☐ ☐ ☐ High or low blood pressure?
- ☐ ☐ ☐ Excessive bleeding or bruising, anemia?
- ☐ ☐ ☐ Chest pain, shortness of breath, tire easily, swollen ankles?
- ☐ ☐ ☐ Heart defects, heart murmur, rheumatic heart disease?
- ☐ ☐ ☐ Angina, arteriosclerosis, stroke or heart attack?
- ☐ ☐ ☐ Skin disorder (other than common acne)?
- ☐ ☐ ☐ Do you eat a well-balanced diet?
- ☐ ☐ ☐ Frequent headaches or migraines?
- ☐ ☐ ☐ Frequent ear infections, colds, throat infections?
- ☐ ☐ ☐ Asthma, sinus problems, hayfever?
- ☐ ☐ ☐ Tonsil or adenoid condition?
- ☐ ☐ ☐ Do you frequently breathe through your mouth?

Have you had allergies or reactions to any of the following?

Yes No DK/U

- ☐ ☐ ☐ Local anesthetics (novocaine, lidocaine, xylocaine)
- ☐ ☐ ☐ Latex (gloves, balloons)
- ☐ ☐ ☐ Aspirin
- ☐ ☐ ☐ Metals (jewelry, clothing snaps)
- ☐ ☐ ☐ Penicillin
- ☐ ☐ ☐ Other antibiotics
- ☐ ☐ ☐ Ibuprofen (Motrin, Advil)
- ☐ ☐ ☐ Acrylics
- ☐ ☐ ☐ Plant pollens
- ☐ ☐ ☐ Animals
- ☐ ☐ ☐ Foods
- ☐ ☐ ☐ Other substances _____

Dental History

Now or in the past, have you had:

Yes No DK/U

- ☐ ☐ ☐ Permanent or extra (supernumerary) teeth removed?
- ☐ ☐ ☐ Supernumerary (extra) or congenitally missing teeth?
- ☐ ☐ ☐ Chipped or injured primary or permanent teeth?
- ☐ ☐ ☐ Any sensitive or sore teeth?
- ☐ ☐ ☐ Bleeding gums, bad taste or mouth odor?
- ☐ ☐ ☐ Jaw fractures, cysts, infections?
- ☐ ☐ ☐ Any teeth treated with root canals or pulpotomies?
- ☐ ☐ ☐ "Gum boils," frequent canker sores or cold sores?
- ☐ ☐ ☐ History of speech problems or speech therapy?
- ☐ ☐ ☐ Difficulty breathing through nose?
- ☐ ☐ ☐ Food impaction between the teeth?
- ☐ ☐ ☐ Mouth breathing habit or snoring at night?
- ☐ ☐ ☐ Frequent oral habits (sucking finger, chewing pen, etc)?
- ☐ ☐ ☐ Teeth causing irritation to lip, cheek or gums?
- ☐ ☐ ☐ Abnormal swallowing (tongue thrust)?
- ☐ ☐ ☐ Tooth grinding or clenching?
- ☐ ☐ ☐ Clicking, locking in jaw joints?
- ☐ ☐ ☐ Soreness in jaw muscles or face muscles?
- ☐ ☐ ☐ Ringing in ears, difficulty in chewing or opening jaw?
- ☐ ☐ ☐ Have you ever been treated for "TMJ" or "TMD" problems?
- ☐ ☐ ☐ Any broken or missing fillings?
- ☐ ☐ ☐ Any serious trouble associated with previous dental treatment?
- ☐ ☐ ☐ Have you ever been diagnosed with gum disease or pyorrhea?
- ☐ ☐ ☐ Have you ever had an orthodontic consultation or treatment before now?

Patient Health Information

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements, that you take.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Have you ever taken any medications to strengthen your bones? Please describe._____

_____

Do you take antibiotic pre-medication before any dental procedures? _____

Do you or have you ever had a substance abuse problem? _____

Do you chew or smoke tobacco? _____

Have you noticed any changes in your face or jaws? _____

Any other physical problems? _____

How often do you brush? _____ How often do you floss? _____

Women: Are you pregnant? ☐ Yes ☐ No Are you trying to become pregnant? ☐ Yes ☐ No

Family Medical History

Have your parents or siblings ever had any of the following health problems? If so, please explain._____

Bleeding disorders _____ Diabetes _____

Arthritis _____ Severe allergies _____

Unusual dental problems _____ Jaw size imbalance _____

Other family medical conditions? _____

_____

Release and Waiver

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Signature _____ Date _____

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 medical or dental health.

Signature _____ Date _____

Medical History Updates or Changes

Changes _____

Signature _____ Date _____

Dental Staff Signature _____ Date _____

Changes _____

Signature _____ Date _____

Dental Staff Signature _____ Date _____

Changes _____

Signature _____ Date _____

Dental Staff Signature _____ Date _____

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Patient Name:
Patient ID:
Date: 6/27/2017
Treatment Stage: (Initial) / Final
Completed By: Child-Adolescent Patient / Parent / (Adult Patient)

Please rate the following characteristics on a scale from 1 to 5.

The position of my (child's) teeth *now*:

1	2	3	4	5
Least Satisfactory		Neutral		Most Satisfactory

My (child's) bite *now*:

1	2	3	4	5
Least Satisfactory		Neutral		Most Satisfactory

My (child's) smile *now*:

1	2	3	4	5
Least Satisfactory		Neutral		Most Satisfactory

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

1	2	3	4	5
Least Satisfactory		Neutral		Most Satisfactory

My (child's) profile *now*:

1	2	3	4	5
Least Satisfactory		Neutral		Most Satisfactory

Your (child's) overall facial appearance *now*:

1	2	3	4	5
Least Satisfactory		Neutral		Most Satisfactory

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Release

I hereby grant Seton Hill University permission to use, reuse, publish and republish photographic portraits and video likenesses of me, pictures or video in which I 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 of full age, and have the right to contract on my own name. I have read the above authorization, release, and agreement.

Name _____

Signature _____ Date _____

Address _____

Phone _____ Email _____

Witness _____ Date _____

Orthodontist _____