WELCOME to Seton Hill University Center for Orthodontics!

We are so thrilled to have you here!
Our goal is to give you YOUR BEST SMILE
in a fun, educational environment.

Get ready to SMILE!

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

Seton Hill
UNIVERSITY

Center for Orthodontics

***TO BE FILLED OUT BY LEGAL GAURDIAN – For Patients ages 10-17 only *** (Please Fill in only highlighted areas)

Seton Hill University Center for Orthodontics Research Information and Informed Consent

DESCRIPTION: Your child is invited to participate in a research study at Seton Hill University Center for Orthodontics that measures anxiety. The study will take place over one scheduled appointment. Before the appointment, your child will be required to watch a short video and answer a few questions about how they feel. Your child's responses will be recorded.

TIME INVOLVEMENT: Participation will consist of 1 appointment. Participation will not require additional time to be scheduled then is already scheduled for the new patient exam

RISKS AND BENEFITS: The risks associated with this study are no greater than risks associated with participation in everyday life. There are no expected benefits to the child for participation in this study.

We cannot and do not guarantee or promise that you will receive any benefits from this study.

The decision whether or not to allow your child to participate in this study will not affect the orthodontic care rendered to your child in any manner whatsoever.

PAYMENTS: There will be no payments associated with your child's participation in the study.

PARTICIPANT'S RIGHTS: If you have read this form and have decided to allow your child to participate in this project, please understand that **participation is voluntary** and **your child does not have to participate in this study**. Choosing to not participate will not negatively effect your child's treatment in anyway. If you choose to participate in the study, **you have the right to withdraw your consent or discontinue your child's participation at any time without penalty or loss of benefits to which you or your child are otherwise entitled**.

Your child's individual privacy will be maintained in all published and written data resulting from the study. Your child's information will remain confidential.

CONTACT INFORMATION:

Questions, Concerns, or Complaints: If you have any questions, concerns or complaints about this research study, its procedures, risks and benefits, or alternative courses of treatment, you should ask the Protocol Director, Dr. Micah Yetter, Seton Hill University Center for Orthodontics. You may contact him now or later at (724) 552-2950.

Independent Contact: If you are not satisfied with how this study is being conducted, or if you have any concerns, complaints, or general questions about the research or your rights as a participant, please contact the Seton Hill University Institutional Review Board (IRB) to communicate with someone independent of the research team at irb@setonhill.edu

***TO BE FILLED OUT BY LEGAL GAURDIAN – For Patients ages 10-17 *** (Please fill in highlighted areas only)

Alternate Contact: If you cannot reach the Protocol Director, please contact the Research Advisor Dr. Daniel Rinchuse at (724) 552-2950

With your permission, the data obtained from your child's responses, will be used as part of a compilation of information regarding anxiety and orthodontic treatment. This information will be reported in a future research paper which will be submitted for publication in a national journal. Your child's identity, however, will not be exposed at any point during this process and privacy will remain intact.

If you agree to allow your child to participate in this research, please *complete the below form. If you have any questions about the study or the information within the informed consent, you can please contact Seton Hill University Center for Orthodontics at 724-552-2950. You can also ask any questions when you check in on the day of your child's new patient exam.*

I, (name of guardian)_____ , have read and fully understand the preceding information within the consent form. If I had any questions, I have had the opportunity to ask questions and had my questions answered. I understand what will be involved with this study and agree to allow my child to whom I have legal guardianship over to participate in this study. I understand that my child's participation in this study is voluntary and not required. I understand that I can withdraw my child from this study at anytime. I agree as well as to be contacted by Seton Hill University Center for Orthodontics about the study if needed.

DATE_____

SIGNATURE OF GUARDIAN (Since participant is under 18 years of age): _____

Signature of faculty, staff, resident, or intern confirming that the guardian does not have any further questions about the study or informed consent OR confirming that any and all guardian questions have been answered. (this is to be signed when the guardian and patient present to the clinic in person.)

_____ _____ _____

(Printed name of faculty, staff, resident, or intern) (Signature of faculty, staff, resident or intern) (Date)

If you would like full disclosure of the study upon completion of the study please leave your email address below:

_____

*This is adapted after: Human Subjects Research. 2010. 6 May 2010. Stanford University. Access date 23 September 2019. http://humansubjects.stanford.edu/research/medical/med_consent.html#forms

TO BE FILLED OUT BY MINOR/CHILD (ages 10-17)

Agreement to Be Part of a Research Study

Good morning, my name is Micah Yetter; I am studying for my master's degree in orthodontics at Seton Hill University. I'm writing a paper about anxiety.

As part of your appointment today you will be asked to view a short video and answer a few questions that describes how you feel. You will have the choice to not answer or to skip any or all questions if you choose. I will use this information to help me write my paper in which your identity will be kept anonymous.

RISKS AND BENEFITS: The risks associated with this study are no greater than risks associated with participation in everyday life. There are no expected benefits for participation in this study.

Your participation is voluntary. You don't have to participate. You may choose to stop participation at anytime. Your treatment will not be affected whether you choose to participate or not.

If you don't want to participate, just do not sign this form.
Thank you,
Micah Yetter DDS

Subjects(child) name _____ Date _____

Subjects(child) signature _____ Date _____

Seton Hill
UNIVERSITY

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

Center for Orthodontics

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

Seton Hill

Center for Orthodontics

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.®

CONFIDENTIAL

Medical Dental History Form for Patients Under Age 18

PATIENT

Date _____

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

Prefers to be called _____ Hobbies, activities _____

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

School _____ Grade _____ Email address(es) _____

Home address _____ City, State, Zip code _____

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

PARENT/GUARDIAN

Custodial parent(s) name(s) _____

Patient lives with *(check all that apply)* ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Grandparent(s) ☐ Other _____

Father's full name _____ Title: ☐ Mr ☐ Dr ☐ Other _____

Occupation _____ Email address _____

Address *(if different)* _____

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

Mother's full name _____ Title: ☐ Mrs ☐ Ms ☐ Dr ☐ Other _____

Occupation _____ Email address _____

Address *(if different)* _____

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 _____

GENERAL INFORMATION

What concerns you about your child's teeth? _____

What concerns your child about his/her teeth? _____

How does your child feel about orthodontic treatment? _____

Who suggested that your child might need orthodontic treatment? _____

Why did you select our office? _____

Describe any previous orthodontic treatment or consultations. _____

Does your child play a musical instrument? _____

Brother/sister name _____ age ____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____

Brother/sister name _____ age ____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____

Brother/sister name _____ age ____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____

Brother/sister name _____ age ____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____

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

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 _____

Who will be responsible for bringing the patient to orthodontic appointments? _____

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 _____

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 _____

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, has your child 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?
- ☐ ☐ ☐ Cancer, tumor, radiation treatment or chemotherapy?
- ☐ ☐ ☐ Endocrine or thyroid problems?
- ☐ ☐ ☐ Diabetes or low sugar?
- ☐ ☐ ☐ Kidney problems?
- ☐ ☐ ☐ 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?
- ☐ ☐ ☐ History of eating disorder (anorexia, bulimia)?
- ☐ ☐ ☐ Frequent headaches or migraines?
- ☐ ☐ ☐ 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)?
- ☐ ☐ ☐ Does your child eat a well-balanced diet?
- ☐ ☐ ☐ Vision, hearing, or speech problems?
- ☐ ☐ ☐ Frequent ear infections, colds, throat infections?
- ☐ ☐ ☐ Asthma, sinus problems, hayfever?
- ☐ ☐ ☐ Tonsil or adenoid condition?
- ☐ ☐ ☐ Does your child frequently breathe through his/her mouth?
- ☐ ☐ ☐ Has your child ever taken intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?
- ☐ ☐ ☐ Has your child ever taken oral bisphosphonates such as Fosamax (alendronate), Actonel(ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone disorders?

Has your child had allergies or reactions to any of the following?

Yes No DK/U

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

Dental History

Now or in the past, has your child had:

Yes No DK/U

- ☐ ☐ ☐ Erupting teeth very early or very late?
- ☐ ☐ ☐ Primary (baby) teeth removed that were not loose?
- ☐ ☐ ☐ Permanent or extra (supernumerary) teeth removed?
- ☐ ☐ ☐ Supernumerary (extra) or congenitally missing teeth?
- ☐ ☐ ☐ Chipped or injured primary or permanent teeth?
- ☐ ☐ ☐ Any sensitive or sore teeth?
- ☐ ☐ ☐ Any lost or broken fillings?
- ☐ ☐ ☐ Jaw fractures, cysts, infections?
- ☐ ☐ ☐ Any teeth treated with root canals or pulpotomies?
- ☐ ☐ ☐ Frequent canker sores or cold sores?
- ☐ ☐ ☐ History of speech problems or speech therapy?
- ☐ ☐ ☐ Difficulty breathing through nose?
- ☐ ☐ ☐ Mouth breathing habit or snoring at night?
- ☐ ☐ ☐ History of speech problems?
- ☐ ☐ ☐ Frequent oral habits (sucking finger, chewing pen, etc)?
- ☐ ☐ ☐ Teeth causing irritation to lip, cheek or gums?
- ☐ ☐ ☐ Tooth grinding or clenching?
- ☐ ☐ ☐ Clicking, locking in jaw joints?
- ☐ ☐ ☐ Soreness in jaw muscles or face muscles?
- ☐ ☐ ☐ Has your child been treated for "TMJ" or "TMD" problems?
- ☐ ☐ ☐ Any broken or missing fillings?
- ☐ ☐ ☐ Any serious trouble associated with previous dental treatment?
- ☐ ☐ ☐ Has your child ever been diagnosed with gum disease or pyorrhea?

Patient Health Information

Do you think that any of your child's activities affect his/her face, teeth or jaws? How? _____

_____

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that your child takes.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Does your child take antibiotic pre-medication before any dental procedures? _____

Does your child have (or ever had) a substance abuse problem? _____

Does your child chew or smoke tobacco? _____

Have you noticed any unusual changes in your child's face or jaws? _____

Any other physical problems? _____

Family Medical History

Have the 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? _____

_____

How often does your child brush? _____ Floss? _____

Release and Waiver

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

Parent/Guardian 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 child's medical or dental health.

Parent/Guardian Signature _____ Date _____

Medical History Updates or Changes

Changes _____

Parent/Guardian Signature _____ Date _____

Dental Staff Signature _____ Date _____

Changes _____

Parent/Guardian Signature _____ Date _____

Dental Staff Signature _____ Date _____

Changes _____

Parent/Guardian Signature _____ Date _____

Dental Staff Signature _____ Date _____

Seton Hill

Center for Orthodontics

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

Seton Hill

Center for Orthodontics

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 the minor named below, pictures or video in which the minor may be included, 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 the parent/ guardian of the minor (under 18 years of age), and have the right to contract on his/ her behalf. I have read the above authorization, release, and agreement.

Name of Guardian _____

Signature _____ Date _____

Address _____

Phone _____ Email _____

Name of Minor _____

Witness _____ Date _____

Orthodontist _____