State College Office
1951 Pine Hall Road Suite 200
State College, PA 16801
814-826-2055

Lock Haven Area Office
10 Linnippi Trail
Lock Haven, PA 17745
570-769-5082

Welcome to Schuchert Orthodontics!

Thank you for choosing our office for your orthodontic needs. Our team strives to treat their patients with the highest quality of care using the most advanced orthodontic treatment methods. We hope to ultimately give you a positive and memorable orthodontic experience, along with a smile that will last a lifetime.

This letter will inform you of what to expect at your first visit with our Team. Our treatment coordinator will first greet you at this appointment and guide you through the orthodontic new patient experience. The treatment coordinator will first review the paperwork that we ask to have completed upon arrival at the office (included in the packet). This will then be followed by simple digital photos and 1 or two orthodontic digital x-rays. After the records have been reviewed with you, one of our doctors will do the orthodontic evaluation that normally only requires a plastic mirror. The doctor will use all of this information to make a custom plan for you or your child and explain this in a way that will be easy for you to understand. If orthodontic treatment or future visits are necessary (such as braces, Invisalign, checkups, etc.) The treatment coordinator will then guide you through the remaining steps of this process.

If treatment is necessary, our financial coordinator will help make a pre-determination of any orthodontic benefit that you may have. We ask that you bring as much of this insurance information with you to the first visit or call prior to the appointment with the information. We will use this information to maximize your understanding of benefit availability that could assist you with any future orthodontic investments with our office.

We are so excited that you have chosen our office for your orthodontic needs. Our Team at Schuchert Orthodontics looks forward to meeting you and making your orthodontic experience as enjoyable as possible.

The Team at Schuchert Orthodontics

CONSENT TO RELEASE INFORMATION TO ESCORTING PARTIES

We request that a Parent/Guardian be present at least every other orthodontic appointment for a comprehensive conversation regarding orthodontic progress and/or questions regarding financial arrangements and/or past due accounts. We recognize, however, that from time to time it may be necessary for someone other than a parent or guardian to accompany the child for treatment. With execution of the Consent to Release Information to Escorting Parties, we are asking you to provide us with written authorization to release your child's or ward's information regarding his or her orthodontic progress, oral hygiene, compliance, or any other necessary information pertaining to the potential success of their orthodontic treatment to a third party.

As the parent and/or guardian of ______________________________, I hereby give consent to Schuchert Orthodontics to provide information about my child's or ward's orthodontic progress, oral hygiene, compliance, or any other necessary information that pertains to the overall success of their orthodontic treatment to the persons listed below. I also understand, as the responsible party for my child's treatment, that Schuchert Orthodontics is requesting my attendance at least at every other appointment as a way to ensure appropriate personal communication on my child's orthodontic treatment.

This Consent to Release Information to Escorting Parties shall be effective immediately, and shall continue in full force and effect until I withdraw it by written notice provided to Schuchert Orthodontics.

____ ____

Parent/Guardian signature Date

Please list below those individuals who may escort your child to their appointments and to whom Schuchert Orthodontics may release the afore described information:

____ ____

____ ____

____ ____

____ ____

Today's Date________________________

PATIENT INFORMATION

Patient Name: ____

Title(Mr./Mrs./Miss)____________________ Prefers to be called: ____

Date of Birth: ______________________________ Male: ______________________Female: ____________________

Home Address: ____

____

Home Phone: _______________________ Cell: ______________________ ___ Work: __________________________

E-Mail Address: ____

RESPONSIBLE PARTY(IES)

1.) Relationship to Patient: ◯Self ◯Spouse ◯Mother ◯ Father ◯Other___________________

Name: ____

Address: ____

____

Home Phone: ____________________ Cell: _________________ ____ Work: ____________________________

E-Mail Address: ____

Date of Birth: ____ __________________________________ Soc. Sec. No.: __________________________________

2.)Relationship to Patient: ◯Self ◯Spouse ◯Mother ◯ Father ◯Other____________________

Name: ____

Address: ____

____

Home Phone: _________________________ Cell: ______________________ ____ Work: _______________________

E-Mail Address: ____

Date of Birth: ____ _________________________________ Soc. Sec. No.: ___________________________________

DENTAL INSURANCE INFORMATION

1.) Policy Holder's Name: ____ Date of Birth: _______________________

Employer: ____ Employer Tel. No.: _________________________

Employer Address: ____

____

Insurance Company: ____ Insurance Co. Tel. No.: ___________________

Insurance Company Address: ____

____

Insured's ID No.:____________________________________ Group No.: _______________________________________

Does this Plan have an orthodontic benefit? ◯ YES ◯ NO, If YES, How Much? $____________________________

2.) Policy Holder's Name: ____ Date of Birth: __________________

Employer: ____ Employer Tel. No.: _________________________

Employer Address: ____

____

Insurance Company: ____ Insurance Co. Tel. No.: ___________________

Insurance Company Address: ____

____

Insured's ID No.:_____________________________________ Group No.: ______________________________________

Does this Plan have an orthodontic benefit? ◯ YES ◯ NO, If YES, How Much? $____________________________

MEDICAL HISTORY

Physician: ______________________________ Last Visit: ____________________

Address: ____

______________________________________Telephone No.: ____________________

Is the patient currently under a physicians care? ◯ YES ◯ NO Reason: ____________________

Is There A History Of: (Circle Yes or No)

Heart Disease	Y	N	Kidney Disease	Y	N	Nasal Blockage	Y	N	Emotional Problem	Y	N
Rheumatic fever	Y	N	Diabetes	Y	N	Drug/Alcohol/Tobacco Use	Y	N	Psychiatric Therapy	Y	N
Heart Murmur	Y	N	Seizures	Y	N	Hepatitis/Jaundice	Y	N	Digestive Disorder	Y	N
High Blood Pressure	Y	N	Asthma	Y	N	Tuberculosis	Y	N	Hospitalization/Surgery	Y	N
AIDS/HIV	Y	N	Arthritis	Y	N	Thyroid Disease	Y	N	Blood Disorder	Y	N
Frequent Colds	Y	N	Birth Defects	Y	N	Major Illness	Y	N	Unusual Childhood Disease	Y	N

If you answered yes to any of the above, Please explain: ______________________________

____

Is the patient currently taking any medication(s) ◯ Yes ◯No Please List: ____________________

______________________________________ (Please use a separate page if necessary)

Does the patient have any food or drug allergies? ◯Yes ◯No If Yes, Please List: ____________________

______________________________________ (Please use a separate page if necessary)

Is the patient taking or taken in the past medications known as Bisphosphonates? ◯Yes ◯No

(Fosomax, Actonel, Boniva, Skelid, Didronel, Aredia, Zometa)

Young Female Patients: Has the patient started monthly menstrual cycles? ◯Yes ◯No When? __________

ORAL HISTORY

General Dentist: ______________________________ Last Visit Date: ____________________

Address: ____

______________________________________Telephone: ____________________

Why is the patient seeking treatment? ______________________________________

What should treatment accomplish? ______________________________________

Is There A History Of: (Circle Yes or No)

Clicking of the Jaw Joints	Y	N	Tongue Thrusting Habit	Y	N	Prior Orthodontics	Y	N
Pain in the Jaw Joints	Y	N	Grinding Teeth	Y	N	Extra Teeth	Y	N
Injuries to the Teeth	Y	N	Pen/Lip/Nail Biting	Y	N	Extraction of Teeth	Y	N
Injuries to the Face	Y	N	Thumb or Finger Sucking	Y	N	Missing Teeth	Y	N
Difficulty Chewing	Y	N	Chewing Gum	Y	N	Speech Problem	Y	N
Fever Blisters/Ulcers	Y	N	Mouth Breathing	Y	N	Dry Mouth	Y	N

RELEASE AND CONSENT

To the best of my knowledge all the preceding answers are true and correct. I hereby give my permission to Schuchert Orthodontics to take the necessary X-Rays, Photos, or Study Models to enable a Complete Diagnosis as well as use of these records for educational purposes.

Signature(Patient /Parent/Guardian): ______________________________Date: __________

Provider Signature: ______________________________Date: __________

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM FOR SCHUCHERT ORTHODONTICS

You may refuse to sign this acknowledgement & authorization. In refusing, we may not be allowed to process your insurance claims

Date: ___________________________

Patient Name(s): ____

PLEASE LIST ANY OTHER PARTIES WHO ARE AUTHROIZED TO HAVE ACCESS TO YOUR HEALTH INFORMATION : (This includes stepparents, grandparents, and any caretakers who can have access to this patient's records):

Name: ____ Relationship: _______________________________

Name: ____ Relationship: ______________________________

Name: ____ Relationship:_______________________________

- I AUTHORIZE CONTACT FROM THIS OFFICE **TO CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Home Phone Confirmation

☐ Work Phone Confirmation ☐ US Postal Service

☐ **Any of the Above**

- I AUTHORIZE **INFORMATION ABOUT THE PATIENT'S HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Home Phone Confirmation

☐ Work Phone Confirmation ☐ US Postal Service

☐ **Any of the Above**

- I APPROVE BEING **CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message ☐ Any of the Above

☐ US Postal Service ☐ None of the above(opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We under current HIPAA Omnibus Rule, provide this information with your knowledge and consent.

*****The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.**

____ ____

Please **print** your name Please **sign** your name

****

Office Use Only

As Privacy Office, I attempt to obtain the patient's (or representatives) signature on this Acknowledgement, but did not because:

It was emergency treatment __________ The patient was unable to sign because __________ Other __________________________

I could not communicate with the patient __________ The patient refused to sign ___________

Signature of Privacy Officer: _______________________________

SIGNATURE ON FILE

I understand that my signature authorizes release of any information relating to my dental insurance claims necessary to pay the claim.

I understand that I am responsible for any balance regardless of my insurance benefits.

I request that payment of authorized benefits be made either to myself or on my behalf to Schuchert Orthodontics.

____ ____

Name of Policy Holder SSN of Policy Holder

Patient Names

____ ____

____ ____

____ ____

Signature of Parent/Guardian Date

RELEASE AUTHORIZING USE OF PERSONAL LIKENESS

I,_____________________________________ consent to the use of my personal image and likeness, including but not limited to images representing and depicting the treatment provided to me and the effect thereof, by Schuchert Orthodontics for:

___ educational purposes only (ex: consultation with patients and their families within Dr.Schuchert's office for the purpose of providing an example and illustrating proposed treatment; colleague presentations) I do **not** consent to the use of my personal image and likeness to be published or posted in advertising or Social Media.

___any lawful use Schuchert Orthodontics deems appropriate, including for treatment, advertising their services to the general public (**including** via social media and electronic media), illustration, and publication at large for educational purposes. I hereby relinquish any and all rights to my likeness or any image of me obtained by any photographic or digital means by Schuchert Orthodontics during the course of my treatment.

I understand and agree that I have no right to be consulted about or approve of any such alterations before my image is used.

I understand that Schuchert Orthodontics will make all reasonable efforts to safeguard my privacy as required by applicable law, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand, however that Schuchert Orthodontics cannot guarantee my complete privacy in the event my image or likeness is used by third parties.

I understand and agree that Schuchert Orthodontics may use information regarding my health condition, including information regarding my diagnosis, course of treatment, my date of birth and/or age and my other relevant medical conditions, in describing the treatment rendered to me as depicted in any image of me.

I understand that Schuchert Orthodontics may not and has not conditioned the rendition of treatment to me upon treatment to me upon my authorization of the use of my image and/or likeness.
I have read the foregoing in its entirety and understand its terms.

______________________________	______________________________
Patient Name	Patient/Guardian Signature
______________________________	________________________
If patient is a minor, guardian name and relationship to patient	Date
__________________________	________________________
Provider Signature	Date

INFORMED CONSENT

for the Orthodontic Patient

Risks and Limitations of Orthodontic Treatment

Successful orthodontic treatment is a partnership between the orthodontist and the patient. The doctor and staff are dedicated to achieving the best possible result for each patient. As a general rule, informed and cooperative patients can achieve positive orthodontic results. While recognizing the benefits of a beautiful healthy smile, you should also be aware that, as with all healing arts, orthodontic treatment has limitations and potential risks. These are seldom serious enough to indicate that you should not have treatment; however, all patients should seriously consider the option of no orthodontic treatment at all by accepting their present oral condition. Alternatives to orthodontic treatment vary with the individual's specific problem, and prosthetic solutions or limited orthodontic treatment may be considerations. You are encouraged to discuss alternatives with the doctor prior to beginning treatment.

Orthodontics and Dentofacial Orthopedics is the dental specialty that includes the diagnosis, prevention, interception and correction of malocclusion, as well as neuromuscular and skeletal abnormalities of the developing or mature orofacial structures.

An orthodontist is a dental specialist who has completed at least two additional years of graduate training in orthodontics at an accredited program after graduation from dental school.

My Life. My Smile. My Orthodontist.®

Results of Treatment

Orthodontic treatment usually proceeds as planned, and we intend to do everything possible to achieve the best results for every patient. However, we cannot guarantee that you will be completely satisfied with your results, nor can all complications or consequences be anticipated. The success of treatment depends on your cooperation in keeping appointments, maintaining good oral hygiene, avoiding loose or broken appliances, and following the orthodontist's instructions carefully.

Length of Treatment

The length of treatment depends on a number of issues, including the severity of the problem, the patient's growth and the level of patient cooperation. The actual treatment time is usually close to the estimated treatment time, but treatment may be lengthened if, for example, unanticipated growth occurs, if there are habits affecting the dentofacial structures, if periodontal or other dental problems occur, or if patient cooperation is not adequate. Therefore, changes in the original treatment plan may become necessary. If treatment time is extended beyond the original estimate, additional fees may be assessed.

Discomfort

The mouth is very sensitive so you can expect an adjustment period and some discomfort due to the introduction of orthodontic appliances. Non-prescription pain medication can be used during this adjustment period.

Relapse

Completed orthodontic treatment does not guarantee perfectly straight teeth for the rest of your life. Retainers will be required to keep your teeth in their new positions as a result of your orthodontic treatment. You must wear your retainers as instructed or teeth may shift, in addition to other adverse effects. Regular retainer wear is often necessary for several years following orthodontic treatment. However, changes after that time can occur due to natural causes, including habits such as tongue thrusting, mouth breathing, and growth and maturation that continue throughout life. Later in life, most people will see their teeth shift. Minor irregularities, particularly in the lower front teeth, may have to be accepted. Some changes may require additional orthodontic treatment or, in some cases, surgery. Some situations may require non-removable retainers or other dental appliances made by your family dentist.

Extractions

Some cases will require the removal of deciduous (baby) teeth or permanent teeth. There are additional risks associated with the removal of teeth which you should discuss with your family dentist or oral surgeon prior to the procedure.

Orthognathic Surgery

Some patients have significant skeletal disharmonies which require orthodontic treatment in conjunction with orthognathic (dentofacial) surgery. There are additional risks associated with this surgery which you should discuss with your oral and/or maxillofacial surgeon prior to beginning orthodontic treatment. Please be aware that orthodontic treatment prior to orthognathic surgery often only aligns the teeth within the individual dental arches. Therefore, patients discontinuing orthodontic treatment without completing the planned surgical procedures may have a malocclusion that is worse than when they began treatment!

Decalcification and Dental Caries

Excellent oral hygiene is essential during orthodontic treatment as are regular visits to your family dentist. Inadequate or improper hygiene could result in cavities, discolored teeth, periodontal disease and/or decalcification. These same problems can occur without orthodontic treatment, but the risk is greater to an individual wearing braces or other appliances. These problems may be aggravated if the patient has not had the benefit of fluoridated water or its substitute, or if the patient consumes sweetened beverages or foods.

Root Resorption

The roots of some patients' teeth become shorter (resorption) during orthodontic treatment. It is not known exactly what causes root resorption, nor is it possible to predict which patients will experience it. However, many patients have retained teeth throughout life with severely shortened roots. If resorption is detected during orthodontic treatment, your orthodontist may recommend a pause in treatment or the removal of the appliances prior to the completion of orthodontic treatment.

Nerve Damage

A tooth that has been traumatized by an accident or deep decay may have experienced damage to the nerve of the tooth. Orthodontic tooth movement may, in some cases, aggravate this condition. In some cases, root canal treatment may be necessary. In severe cases, the tooth or teeth may be lost.

Periodontal Disease

Periodontal (gum and bone) disease can develop or worsen during orthodontic treatment due to many factors, but most often due to the lack of adequate oral hygiene. You must have your general dentist, or if indicated, a periodontist monitor your periodontal health during orthodontic treatment every three to six months. If periodontal problems cannot be controlled, orthodontic treatment may have to be discontinued prior to completion.

Injury From Orthodontic Appliances

Activities or foods which could damage, loosen or dislodge orthodontic appliances need to be avoided. Loosened or damaged orthodontic appliances can be inhaled or swallowed or could cause other damage to the patient. You should inform your orthodontist of any unusual symptoms or of any loose or broken appliances as soon as they are noticed. Damage to the enamel of a tooth or to a restoration (crown, bonding, veneer, etc.) is possible when orthodontic appliances are removed. This problem may be more likely when esthetic (clear or tooth colored) appliances have been selected. If damage to a tooth or restoration occurs, restoration of the involved tooth/teeth by your dentist may be necessary.

Headgears

Orthodontic headgears can cause injury to the patient. Injuries can include damage to the face or eyes. In the event of injury or especially an eye injury, however minor, immediate medical help should be sought. Refrain from wearing headgear in situations where there may be a chance that it could be dislodged or pulled off. Sports activities and games should be avoided when wearing orthodontic headgear.

Temporomandibular (Jaw) Joint Dysfunction

Problems may occur in the jaw joints, i.e., temporomandibular joints (TMJ), causing pain, headaches or ear problems. Many factors can affect the health of the jaw joints, including past trauma (blows to the head or face), arthritis, hereditary tendency to jaw joint problems, excessive tooth grinding or clenching, poorly balanced bite, and many medical conditions. Jaw joint problems may occur with or without orthodontic treatment. Any jaw joint symptoms, including pain, jaw popping or difficulty opening or closing, should be promptly reported to the orthodontist. Treatment by other medical or dental specialists may be necessary.

Impacted, Ankylosed, Unerupted Teeth

Teeth may become impacted (trapped below the bone or gums), ankylosed (fused to the bone) or just fail to erupt. Oftentimes, these conditions occur for no apparent reason and generally cannot be anticipated. Treatment of these conditions depends on the particular circumstance and the overall importance of the involved tooth, and may require extraction, surgical exposure, surgical transplantation or prosthetic replacement.

Occlusal Adjustment

You can expect minimal imperfections in the way your teeth meet following the end of treatment. An occlusal equilibration procedure may be necessary, which is a grinding method used to fine-tune the occlusion. It may also be necessary to remove a small amount of enamel in between the teeth, thereby "flattening" surfaces in order to reduce the possibility of a relapse.

Non-Ideal Results

Due to the wide variation in the size and shape of the teeth, missing teeth, etc., achievement of an ideal result (for example, complete closure of a space) may not be possible. Restorative dental treatment, such as esthetic bonding, crowns or bridges or periodontal therapy, may be indicated. You are encouraged to ask your orthodontist and family dentist about adjunctive care.

Third Molars

As third molars (wisdom teeth) develop, your teeth may change alignment. Your dentist and/or orthodontist should monitor them in order to determine when and if the third molars need to be removed.

Continued on next page

Patient or Parent/Guardian Initials __________

Patient ______________________________ Date ______________

Allergies

Occasionally, patients can be allergic to some of the component materials of their orthodontic appliances. This may require a change in treatment plan or discontinuance of treatment prior to completion. Although very uncommon, medical management of dental material allergies may be necessary.

General Health 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. It is imperative that you inform your orthodontist of any changes in your general health status.

Use of Tobacco Products

Smoking or chewing tobacco has been shown to increase the risk of gum disease and interferes with healing after oral surgery. Tobacco users are also more prone to oral cancer, gum recession, and delayed tooth movement during orthodontic treatment. If you use tobacco, you must carefully consider the possibility of a compromised orthodontic result.

Temporary Anchorage Devices

Your treatment may include the use of a temporary anchorage device(s) (i.e. metal screw or plate attached to the bone.) There are specific risks associated with them.

It is possible that the screw(s) could become loose which would require its/their removal and possibly relocation or replacement with a larger screw. The screw and related material may be accidentally swallowed. If the device cannot be stabilized for an adequate length of time, an alternate treatment plan may be necessary.

It is possible that the tissue around the device could become inflamed or infected, or the soft tissue could grow over the device, which could also require its removal, surgical excision of the tissue and/or the use of antibiotics or antimicrobial rinses.

It is possible that the screws could break (i.e. upon insertion or removal.) If this occurs, the broken piece may be left in your mouth or may be surgically removed. This may require referral to another dental specialist.

When inserting the device(s), it is possible to damage the root of a tooth, a nerve, or to perforate the maxillary sinus. Usually these problems are not significant; however, additional dental or medical treatment may be necessary.

Local anesthetic may be used when these devices are inserted or removed, which also has risks. Please advise the doctor placing the device if you have had any difficulties with dental anesthetics in the past.

If any of the complications mentioned above do occur, a referral may be necessary to your family dentist or another dental or medical specialist for further treatment. Fees for these services are not included in the cost for orthodontic treatment.

Patient or Parent/Guardian Initials __________

ACKNOWLEDGEMENT

I hereby acknowledge that I have read and fully understand the treatment considerations and risks presented in this form. I also understand that there may be other problems that occur less frequently than those presented, and that actual results may differ from the anticipated results. I also acknowledge that I have discussed this form with the undersigned orthodontist(s) and have been given the opportunity to ask any questions. I have been asked to make a choice about my treatment. I hereby consent to the treatment proposed and authorize the orthodontist(s) indicated below to provide the treatment. I also authorize the orthodontist(s) to provide my health care information to my other health care providers. I understand that my treatment fee covers only treatment provided by the orthodontist(s), and that treatment provided by other dental or medical professionals is not included in the fee for my orthodontic treatment.

____
Signature of Patient/Parent/Guardian Date

____
Signature of Orthodontist/Group Name Date

____
Witness Date

CONSENT TO UNDERGO ORTHODONTIC TREATMENT

I hereby consent to the making of diagnostic records, including x-rays, before, during and following orthodontic treatment, and to the above doctor(s) and, where appropriate, staff providing orthodontic treatment prescribed by the above doctor(s) for the above individual. I fully understand all of the risks associated with the treatment.

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I hereby authorize the above doctor(s) to provide other health care providers with information regarding the above individual's orthodontic care as deemed appropriate. I understand that once released, the above doctor(s) and staff has(have) no responsibility for any further release by the individual receiving this information.

CONSENT TO USE OF RECORDS

I hereby give my permission for the use of orthodontic records, including photographs, made in the process of examinations, treatment, and retention for purposes of professional consultations, research, education, or publication in professional journals.

____
Signature Date

____
Witness Date

I have the legal authority to sign this on behalf of

____
Name of Patient

____
Relationship to Patient

Notes

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DOCTOR'S COPY

My Life. My Smile. My Orthodontist.®

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