North Seattle ORTHODONTICS

creating smiles you love to share

Dr. Elizabeth Lyons, DDS, MSD

Welcome to our office. So that we may become better acquainted, please complete both sides of this form.

ADULT PATIENT INFORMATION

Name: _____ Preferred name: _____ Sex: _____

Home address: _____ City: _____ State: _____ Zip: _____

Birthdate: _____ Age: _____ Patient Interests: _____

Home Phone: _____ E-Mail Address: _____

Social Security # _____

Who noticed the orthodontic problem? ☐ Patient ☐ Dentist ☐ Other _____

Describe the orthodontic problem in your own words: _____

Do you know a patient currently in our practice? If so, whom? _____

Patient's Dentist: _____ Referred by: _____

Do you have any concerns about orthodontic treatment?

☐ appearance of appliances ☐ cost ☐ length of treatment time ☐ results ☐ discomfort ☐ other - explain

_____

Occupation: _____

Employer: _____ Address: _____

Work Phone: _____ Work E-Mail address (optional): _____

FAMILY AND ACCOUNT INFORMATION

Spouse's Name: _____ Employer: _____ Work Phone: _____

Person responsible for account: _____

Person responsible for account if other than self or spouse:

Name: _____ Relationship to you? _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Employer: _____ Work Phone: _____

Do you have insurance? Please complete the Insurance Information Sheet to help us assist you in determining benefits.

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your

dental care. All information will be kept completely confidential. Please inform us if any changes should occur.

MEDICAL HISTORY

Physician's Name: _____ Address: _____ Phone: _____

Have you experienced any health problems? ☐ No ☐ Yes Explain: _____
Have you ever had any surgery? ☐ No ☐ Yes Explain: _____
Any major change in your health recently? ☐ No ☐ Yes Explain: _____
Are you currently under a physician's care? ☐ No ☐ Yes Explain: _____
Are you currently taking any medications? ☐ No ☐ Yes List: _____
Are you allergic to any medications? ☐ No ☐ Yes List: _____
Have you received a blood transfusion? ☐ No ☐ Yes Reason: _____
Have your tonsils or adenoids been removed? ☐ No ☐ Yes When: _____
Have you been in a risk group for AIDS? ☐ No ☐ Yes Explain: _____
Have you ever been a smoker or used tobacco? ☐ No ☐ Yes Explain: _____

Please check if you have had any of the following conditions: _____

Heart Murmur	☐ No ☐ Yes	Hepatitis	☐ No ☐ Yes	Emotional Problems	☐ No ☐ Yes
Heart Surgery	☐ No ☐ Yes	Diabetes	☐ No ☐ Yes	Frequent Headaches	☐ No ☐ Yes
Rheumatic Fever	☐ No ☐ Yes	Kidney Disease	☐ No ☐ Yes	Nervous/Anxious	☐ No ☐ Yes
Endocrine Disorders	☐ No ☐ Yes	Liver Disease	☐ No ☐ Yes	Cancer	☐ No ☐ Yes
Prolonged Bleeding	☐ No ☐ Yes	Tuberculosis	☐ No ☐ Yes	Bone Disorders	☐ No ☐ Yes
Anemia	☐ No ☐ Yes	Asthma	☐ No ☐ Yes	Growth Disorders	☐ No ☐ Yes
Blood Disease	☐ No ☐ Yes	Bronchitis	☐ No ☐ Yes	Mouth Breather	☐ No ☐ Yes
Developmental Disorder	☐ No ☐ Yes	Epilepsy	☐ No ☐ Yes	Herpes (fever blisters)	☐ No ☐ Yes
Hives/Rash	☐ No ☐ Yes	Fainting	☐ No ☐ Yes	Tonsillitis	☐ No ☐ Yes

Is there any other condition or problem that you think we should know about? _____

Comments: _____

DENTAL HISTORY

Dentist's Name: _____ Address: _____ Phone: _____
Dental Specialist Name: _____ Address: _____ Phone: _____

Frequency of dental checks: ☐ 3x /year ☐ 2 x /year ☐ 1x/year ☐ Only if a problem exists Date of last visit: _____

Do you require premedication prior to dental treatment? ☐ No ☐ Yes Explain: _____
Is there any unfinished care to be completed by your dentist? ☐ No ☐ Yes Explain: _____
Are you frightened about dental treatment? ☐ No ☐ Yes Explain: _____
Have you had an unpleasant experience in a dental office? ☐ No ☐ Yes Explain: _____
Have you had any face or dental injuries? ☐ No ☐ Yes Explain: _____
Do you play a musical instrument? ☐ No ☐ Yes What instrument? _____
Have you consulted an orthodontist previously? ☐ No ☐ Yes Explain: _____
Have teeth (either primary or permanent) been removed? ☐ No ☐ Yes Explain: _____
Have you had any previous orthodontic treatment? ☐ No ☐ Yes With whom: _____
Are you satisfied with prior treatment? ☐ No ☐ Yes Explain: _____
Have you noticed any changes in your bite or dental alignment recently? ☐ No ☐ Yes Explain: _____

What are the chief concerns you have related to the position of your teeth or bite:

☐ Aesthetic ☐ Cleaning ☐ Comfort ☐ Ability to chew ☐ Stability

Please elaborate: _____

What concerns has your dentist(s) expressed concerning your bite or dental alignment:

☐ Wear or fractures of teeth
☐ Bone or gum tissue loss
☐ Alignment of teeth prior to restorative dental work (crown, bridge, etc.)
☐ Difficulty with cleaning related to alignment of teeth
☐ Jaw joint or muscle tightness or discomfort
☐ Other _____

Please check if there is any history of:

☐ Clenching teeth ☐ Muscular soreness around head/neck ☐ Jaw joint soreness ☐ Jaw joint popping
☐ Grinding teeth ☐ Headaches (more than normal) ☐ Jaw joint clicking ☐ Ringing in the ears
☐ Speech problems (if so, which sounds: _____) ☐ Mouth breathing: Awake _____ Asleep _____

Is there any other information that might be helpful? _____

Patient's Signature: _____ Date: _____ Reviewed By: _____

STATEMENT OF PRIVACY PRACTICES

NORTH SEATTLE ORTHODONTICS

Our office is dedicated to protecting the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principal concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect our obligations and your rights.

PROTECTING YOUR PERSONAL HEALTHCARE INFORMATION

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given or disclosed to anyone – even family members – without your consent or written authorization. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality, integrity, and access to your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

COLLECTING PROTECTED HEALTHCARE INFORMATION (PHI)

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

DISCLOSURE OF YOUR PROTECTED HEALTHCARE INFORMATION

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing or fund-raising purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards unless you direct us otherwise. We will never use, disclose, sell, or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use, or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI

YOUR RIGHTS AS OUR PATIENT

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

An expanded, and complete copy of our Statement of Privacy Practices, is available for your review.

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of North Seattle Orthodontics. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

North Seattle Orthodontics reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, protected health information (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

Spouse only	**☐ YES**	**☐ NO**
OR		
Any Member of my immediate family: (i.e. Spouse, Children, Siblings, etc.)	**☐ YES**	**☐ NO**
Any Member of my extended family: (i.e. Parents, Grandchildren)	**☐ YES**	**☐ NO**
Other:	**☐ YES**	**☐ NO**

Name of patient (please print):

Patient signature:

Patient's personal representative: (Please Print):

Personal Rep's signature:

Representative's Phone Number:	**Date:**

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained

Provided Prior to Treatment?	**☐ YES**	**☐ NO**	**Date Statement Provided:**
Reason for not obtaining patient signature	☐	**Needed more time to review Statement**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	