



Dr. Elizabeth Lyons, DDS, MSD

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

CHILD PATIENT INFORMATION

Name: Preferred name: Sex:

Home address: City: State: Zip:

Birth date: Age: School: Grade:

Patient resides with: Mother Father Both Other

Home Phone: Patient Interests:

Who noticed the orthodontic problem? Patient Parent Other

Please describe your child's orthodontic problem:

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

Patient's Dentist: Referred by:

Family E-mail address:

FAMILY AND ACCOUNT INFORMATION

Parent's Marital Status: Married Widowed Divorced Single Separated

Name: PARENT (Mother, Father, other:) PARENT (Mother, Father, other:)

Address (if different than above):

Phone (if different than above):

Occupation:

Employer:

Business Phone:

Birth Date/Social Security #

Person responsible for account if other than parent:

Name:

Address: Phone:

Do you have insurance? Please complete the Insurance Information Sheet to help us assist you in determining benefits. 11011 Meridian Ave N Suite 304 Seattle WA 98133 206-523-1047 www.northseattleortho.com

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: _____

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

Please check if your child has had any of the following conditions:

- | | | | | | |
|------------------------|--|----------------|--|-------------------------|--|
| Heart Murmur | <input type="checkbox"/> No <input type="checkbox"/> Yes | Hepatitis | <input type="checkbox"/> No <input type="checkbox"/> Yes | Emotional Problems | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Heart Surgery | <input type="checkbox"/> No <input type="checkbox"/> Yes | Diabetes | <input type="checkbox"/> No <input type="checkbox"/> Yes | Frequent Headaches | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Rheumatic Fever | <input type="checkbox"/> No <input type="checkbox"/> Yes | Kidney Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes | Nervous/Anxious | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Endocrine Disorders | <input type="checkbox"/> No <input type="checkbox"/> Yes | Liver Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes | Cancer | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Prolonged Bleeding | <input type="checkbox"/> No <input type="checkbox"/> Yes | Tuberculosis | <input type="checkbox"/> No <input type="checkbox"/> Yes | Bone Disorders | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Anemia | <input type="checkbox"/> No <input type="checkbox"/> Yes | Asthma | <input type="checkbox"/> No <input type="checkbox"/> Yes | Growth Disorders | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Blood Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes | Bronchitis | <input type="checkbox"/> No <input type="checkbox"/> Yes | Mouth Breather | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Developmental Disorder | <input type="checkbox"/> No <input type="checkbox"/> Yes | Epilepsy | <input type="checkbox"/> No <input type="checkbox"/> Yes | Herpes (fever blisters) | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Hives/Rash | <input type="checkbox"/> No <input type="checkbox"/> Yes | Fainting | <input type="checkbox"/> No <input type="checkbox"/> Yes | Tonsillitis | <input type="checkbox"/> No <input type="checkbox"/> Yes |
- Is there any other condition or problem that you think we should know about? _____

Comments: _____

GROWTH INFORMATION

Growth can be an important factor in orthodontic treatment planning, therefore your answers to the following questions are needed to aid in our selection of treatment alternatives:

- Has your son or daughter reached puberty? No Yes
- Girls: Has she started menstruation? No Yes Date: _____
- Boys: Has voice changed? No Yes Date: _____
- Height _____ Do you feel that growth is complete? No Yes
- Father's Height _____ Mother's Height _____ Adopted? No Yes
- Names and Birthdates of Siblings: _____
- Have either siblings or parents had orthodontic care? No Yes With Whom: _____

DENTAL HISTORY

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

Frequency of dental checks: Twice a year Once a year Only if a problem exists Never Date of last visit: _____

- Is there any unfinished care to be completed by the dentist? No Yes Explain: _____
- Is your child frightened about dental treatment? No Yes Explain: _____
- Has your child had an unpleasant experience in a dental office? No Yes Explain: _____
- Has your child had any face or dental injuries? No Yes Explain: _____
- Does your child play a musical instrument? No Yes What instrument? _____
- Have you consulted an orthodontist previously? No Yes With Whom? _____
- Have teeth (either primary or permanent) been removed? No Yes Explain: _____
- Has your child had any previous orthodontic treatment? No Yes With Whom? _____
- Are you satisfied with prior treatment? No Yes Explain: _____
- Is there any history of thumb or finger sucking? No Yes When Stopped: _____

Please check if there is any history of:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Clenching teeth | <input type="checkbox"/> Muscular soreness around head/neck | <input type="checkbox"/> Jaw joint soreness | <input type="checkbox"/> Jaw joint popping |
| <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Headaches (more than normal) | <input type="checkbox"/> Jaw joint clicking | <input type="checkbox"/> Ringing in the ears |
| <input type="checkbox"/> Speech problems (if so, which sounds: _____) | | <input type="checkbox"/> Mouthbreathing: Awake _____ | Asleep _____ |

Is there any other information that might be helpful? _____

Parent'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 | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| OR | | |
| Any Member of my immediate family: (i.e. Spouse, Children, Siblings, etc.) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Any Member of my extended family: (i.e. Parents, Grandchildren) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Other: | <input type="checkbox"/> YES | <input type="checkbox"/> 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? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Date Statement Provided: |
| Reason for not obtaining patient signature | <input type="checkbox"/> | Needed more time to review Statement | |
| | <input type="checkbox"/> | Wanted to consult another person before signing | |
| | <input type="checkbox"/> | Physically unable to sign | |
| | <input type="checkbox"/> | No reason offered | |
| | <input type="checkbox"/> | Other: | |

Our patients are also our friends. Please tell us about yourself so that we can get to know you better.

The thing I can't wait to change about my smile is

The thing I like best about my smile is

THANK YOU!

Presenting: _____
 (Your Name)

After High School I plan to

I have _____ friends on Instagram



My birthday is _____

I am _____ years old and in the _____ grade at _____ school



The thing that most people don't know about me is



I go to _____ school and my favorite

subject is _____

I'm really good at

My favorite hobby/sport is



My favorite vacation spot is

My favorite book series is

I love to eat _____

My friend(s) _____

_____ are also patients here.

