



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

Legal Name (First and Last): Preferred name:

Legal Sex: Pronouns: She/Her He/Him They/Them Other (Circle all that apply)

Birth date: Email Address:

Primary Phone: Secondary Phone: Cell / Home / Work (Circle One)

Home Address: City State: Zip:

How did you hear about our office? (If an individual, please list their name & relationship to you)

Occupation: Employer:

Who has the orthodontic concern(s)? Please check all that apply Patient Dentist Both Other

Please describe the orthodontic concern(s) in your own words:

Please indicate the chief concerns you have related to the position of your teeth or bite (Select all that apply):

- Aesthetics Oral Hygeine Comfort Stability of teeth Ability to eat/chew Speech ability

What concerns do you have about orthodontic treatment (Select all that apply)?

- Appearance of appliances Cost Length of treatment Results Discomfort None

Please indicate which concern(s) your dentist(s) have expressed concerning your bite/dental alignment (Select all that apply)

- Wear or fractures of teeth Difficulty with oral hygeine related to alignment of teeth
Bone or gum tissue loss Jaw joint or muscle tightness/discomfort
Alignment prior to restorative dental work (implant, crown, bridge, etc)
Other

ACCOUNT INFORMATION

Person financially responsible for account if other than yourself:

Name: Relationship to you:

Primary Phone: Employer: Cell / Home / Work (Circle One)

Address: City: State: Zip:

Your answers to the following questions will help us when selecting the safest and most effective means of providing you care. All information will be kept completely confidential. Please inform us if any changes should occur.

## MEDICAL HISTORY

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

- Have you had any serious health concerns? -----  No  Yes Explain: \_\_\_\_\_
- Have you ever had any surgery? -----  No  Yes Explain: \_\_\_\_\_
- Any major changes in your health recently? -----  No  Yes Explain: \_\_\_\_\_
- Are you currently under a specialist's care? -----  No  Yes Explain: \_\_\_\_\_
- Are you currently taking any medications? -----  No  Yes List: \_\_\_\_\_
- Are you currently taking bisphosphonates? -----  No  Yes Explain: \_\_\_\_\_
- Are you allergic to any medications? -----  No  Yes List: \_\_\_\_\_
- Have you received a blood transfusion? -----  No  Yes Reason: \_\_\_\_\_
- Have your tonsils\adenoids been removed? -----  No  Yes When: \_\_\_\_\_
- Have you ever vaped or used tobacco? -----  No  Yes Explain: \_\_\_\_\_

Have you had/do you have any of the following conditions:

- |   |  |  |
|---|--|--|
| Heart Murmur ----- <input type="checkbox"/> No <input type="checkbox"/> Yes         | Hepatitis ----- <input type="checkbox"/> No <input type="checkbox"/> Yes     | Mental Health Concerns -- <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   | Anxiety ----- <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 Breathing ----- <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           |

Are there any other medical concerns that you think we should know about? \_\_\_\_\_

## DENTAL HISTORY

Dentist's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Dental Specialist Name: \_\_\_\_\_ Specialist Type: \_\_\_\_\_ Phone: \_\_\_\_\_

Frequency of dental checks:  3x / year  2x / year  1x / year  Only if problem exists Date of last cleaning \_\_\_\_\_

- Is there any unfinished care to be completed by the 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 facial or dental injuries? -----  No  Yes Explain: \_\_\_\_\_
- Do you play a woodwind or brass instrument? -----  No  Yes What instrument? \_\_\_\_\_
- Have teeth (either primary or permanent) been removed? -----  No  Yes Explain: \_\_\_\_\_
- Have you consulted an orthodontist previously? -----  No  Yes With Whom? \_\_\_\_\_
- Have you had any previous orthodontic treatment? -----  No  Yes With Whom? \_\_\_\_\_
- If so, were you satisfied with prior treatment and results? -----  No  Yes Explain: \_\_\_\_\_
- Have you noticed any changes in your bite/dental alignment recently?--  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"/> Mouth breathing while awake    |
| <input type="checkbox"/> Grinding teeth               | <input type="checkbox"/> Jaw joint soreness/clicking/popping          | <input type="checkbox"/> Mouth breathing while sleeping |
| <input type="checkbox"/> Headaches (more than normal) | <input type="checkbox"/> Speech problems (if so, which sounds: _____) |   |

Is there any other dental information you think we should know? \_\_\_\_\_

## 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

<b>Provided Prior to Treatment?</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<b>Date Statement Provided:</b>
<b>Reason for not obtaining patient signature</b>	<input type="checkbox"/>	<b>Needed more time to review Statement</b>	
	<input type="checkbox"/>	<b>Wanted to consult another person before signing</b>	
	<input type="checkbox"/>	<b>Physically unable to sign</b>	
	<input type="checkbox"/>	<b>No reason offered</b>	
	<input type="checkbox"/>	<b>Other:</b>	