

North Seattle ORTHODONTICS

Dr. Elizabeth Lyons, DDS, MSD

Dr. Roy Gunsolus, DDS

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.

11011 Meridian Ave N Suite 304 Seattle, WA 98113 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: _____
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 <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: _____

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 Difficulty with cleaning related to alignment of teeth
 Bone or gum tissue loss Jaw joint or muscle tightness or discomfort
 Alignment of teeth prior to restorative dental work (crown, bridge, etc.)
 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
11011 Meridian Ave N
Seattle, WA 98113
(206) 523-1047

Our office is dedicated to protect the privacy right of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect 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 dental care operations. Your personal health information will never be otherwise given to anyone – even family members – without your written consent. 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 of 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 Health Information

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental 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 Health 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 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.

Patient Rights

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.

We thank you for being a patient at North Seattle Orthodontics. Please let us know if you have any questions concerning your privacy rights and the protection your personal health information.

**North Seattle Orthodontics
 Drs. Lyons & Gunsolus
 11011 Meridian Ave N. Suite 304
 Seattle, Washington 98133
 206.523.1047**

Acknowledgement of Receipt of Notice of Privacy Practices - HIPAA

I certify that I have received a copy of North Seattle Orthodontics Notice of Privacy Practices. The Notice 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's health care operations. The Notice of Privacy Practices also describes my rights and North Seattle Orthodontics duties with respect to my protected health information. The Notice of Privacy Practices is posted in the facility.

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

ADDITIONAL DISCLOSURE AUTHORITY			
In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.			
ANY MEMBER OF MY IMMEDIATE FAMILY	<input type="checkbox"/>	YES	<input type="checkbox"/>
SPOUSE ONLY	<input type="checkbox"/>	YES	<input type="checkbox"/>
OTHER (PLEASE SPECIFY):	<input type="checkbox"/>	YES	<input type="checkbox"/>
	<input type="checkbox"/>		<input type="checkbox"/>

 Name of Patient or Personal Representative

 Signature of Patient or Personal Representative

 Date

 Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE

RECORD OF ACKNOWLEDGEMENT NOT OBTAINED			
PROVIDED PRIOR TO TREATMENT?	<input type="checkbox"/>	YES	<input type="checkbox"/>
		NO	
DATE PROVIDED:			
REASON FOR DENIAL:	<input type="checkbox"/>	NEEDED MORE TIME TO REVIEW NOTICE OF PRIVACY PRACTICES	
	<input type="checkbox"/>	WANTED TO CONSULT WITH ANOTHER PERSON, BEFORE SIGNING.	
	<input type="checkbox"/>	UNABLE TO SIGN.	
	<input type="checkbox"/>	REASON NOT GIVEN.	
	<input type="checkbox"/>	OTHER (EXPLAIN):	
	<input type="checkbox"/>		