



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.

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.

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: _____

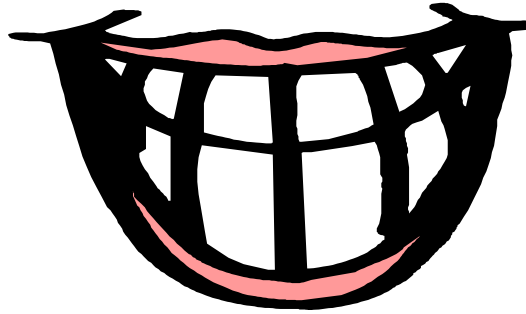
Our patients are also our friends. Please tell us about yourself so that we can get to know you better.

Presenting!



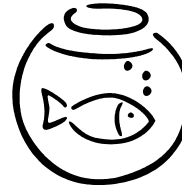
When I grow up I want to be a

(Your Name)



These friends come here for braces, too!

I like to



I have a pet, it is a

named _____

I'm really good at

My birthday is _____.

I am _____ years old and in the _____ grade _____ at _____ School.



My favorite Sport is:

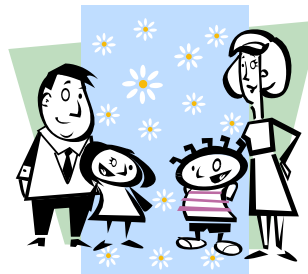
My favorite thing about school is

My least favorite subject in school is



My favorite food is

My favorite TV show is



I have _____ brother and _____ sister.



Thank you!

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"/>
		NO	<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"/>		