



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 <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 2x/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

Our office is dedicated to protect 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 your 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 Health 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 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 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.

IF you'd like a full and complete copy of our Statement of Privacy Practices, please ask at the front desk.

North Seattle Orthodontics
11011 Meridian Avenue N. * Seattle, Washington 98133 - 206-523-1047

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Seattle, Washington 98133

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		
<i>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 the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)</i>		
Spouse only	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any Member of my extended family: (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 Representative's signature: _____		
Representative's Telephone 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 of Privacy Practices
	<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: _____