A

BOTHELL
ORTHODONTICS

Patient Information:

Legal First Name:_____

Legal Last Name:_____

Birthdate:_____Gender:_____

Address: _____

Contact Info:

Phone: _____Text Reminders? (circle one) Y N

Email: _____Email Reminders? (circle one) Y N

Phone 2/Email 2:_____

How did you hear about us?_____

Dental Insurance Information:

Subscribers Legal Name: _____

Subscribers Employer:_____

Subscribers Birthdate: _____

Insurance Company: _____

Insurance Phone #:_____

Subscriber ID #:_____

Group #:_____

If you have dual coverage:

Subscribers Legal Name: _____

Subscribers Employer:_____

Subscribers Birthdate: _____

Insurance Company: _____

Insurance Phone #:_____

Subscriber ID #:_____

Group #:_____

Medical History:

Physician: _____ City: _____ Phone: _____

Do you have any of the following?

- ☐ Diabetes
- ☐ Headaches
- ☐ Heart Disease or Murmur
- ☐ Rheumatic Fever
- ☐ Bone Disorder
- ☐ Eye or Ear problems
- ☐ Snoring
- ☐ Fainting or dizziness
- ☐ Tuberculosis
- ☐ Anemia
- ☐ Epilepsy
- ☐ Asthma or Hay Fever
- ☐ Kidney Disease
- ☐ Grinding
- ☐ Hepatitis or Liver Disease
- ☐ Prolonged Bleeding
- ☐ Nervous Disorders
- ☐ Endocrine Disorders
- ☐ Sleep Apnea
- ☐ Speech Problems
- ☐ Behavior Problems
- ☐ Emotional Problems
- ☐ Slow in Learning
- ☐ HIV/AIDS
- ☐ Other _____

Please check any of the following that apply to you:

- ☐ Taking any medications at this time? if so please be specific: _____
- ☐ Any Allergies? _____
- ☐ Any allergic or unfavorable reactions to any drug or medication? _____

Dental History

Dentist: _____ Dentist Phone: _____ Approx. Date of Last Visit: _____

Check any of the following that apply and explain below:

- ☐ Any injury to the face, mouth, or teeth?
- ☐ Have you ever sucked you thumb or finger?
  if so, until what age? _____
- ☐ Do you grind or clench your teeth during the day or night?
- ☐ Do you have any speech difficulty?
- ☐ Do you have any difficulty chewing?
- ☐ Difficulty cleaning your teeth?
- ☐ Pain or noise from jaw joint?
- ☐ Awareness of any gum or bone problems around the teeth?
- ☐ Inability to open mouth wide or move jaw normally?
- ☐ Prior orthodontics work or consultation with an orthodontist?
- ☐ Concerned about the appearance of your teeth?
- ☐ Are you concerned about the appearance of your face and/or jaw structure?

Comments: _____

_____

What is the primary reason for seeking an orthodontics examination?

_____

_____

Have you seen an orthodontist previously? Why are you seeking a second opinion?

_____

_____

I understand that the information that I have given is correct to the best of my knowledge, and that it is my responsibility to info this office of any changes. This office reserves the right to verify the credit status of potential and/or parents of patients prior to extending credit for treatment fees.

Signature _____ Relationship to Patient: _____

Updates (date and initial) _____

STATEMENT OF PRIVACY PRACTICES OF BOTHELL 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.

Jeremy Chaison DDS, MSD Bothell Orthodontics
19214 Bothell Way NE, Ste A Bothell, Washington 98011 | 425-483-2828

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 Bothell 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.

Bothell 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	☐ YES	☐ NO
OR		
Any Member of my immediate family: (i.e. Spouse, Children, Siblings, etc.)	☐ YES	☐ NO
Any Member of my extended family: (i.e. Parents, Grandchildren)	☐ YES	☐ NO
Other:	☐ YES	☐ NO
Name of patient (please print):		
Patient signature:		

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained

Provided Prior to Treatment?	☐ YES	☐ NO	Date Statement Provided:
Reason for not obtaining patient signature	☐	Needed more time to review Statement	
	☐	Wanted to consult another person before signing	
	☐	Physically unable to sign	
	☐	No reason offered	
	☐	Other:	

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ORTHODONTIC INSURANCE AUTHORIZATION

Patient Name: _____ Patient ID: _____
(Office Use)

I hereby authorize releases any information relating to my insurance.

Signature _____ Date:_____

I hereby authorize payment of insurance benefits directly to the above-named orthodontist.

Signature _____ Date:_____

I understand that the above-named orthodontist is not a member of any insurance plan. We also do not accept Apple Care or DSHS insurance.

Signature _____ Date:_____

PHOTO RELEASE AUTHORIZATION

I, _____, hereby authorize Bothell Orthodontics (Dr. Jeremy B Chaison) to disclose facial and/or dental photographs of the following patient as approved below:

Patient Name: _____ Patient Date of Birth: _____

Please check the appropriate answer to each of the following questions:

1. May the patient's picture be displayed on the reception computer screen for patient sign in purposes?
   - ☐ Yes
   - ☐ No
2. May the patient picture be displayed on the office website, Facebook/Instagram account and/or within the office for the purpose of informing patients of the positive outcome we have achieved?
   - ☐ Yes
   - ☐ No
3. May the patient picture be displayed on the office website, Facebook/Instagram account and/or within the office if they are a contest winner?
   - ☐ Yes
   - ☐ No
4. May the patients records including photographs to be used for the purposes of professional consultations, research, education to publication in professional journals?
   - ☐ Yes
   - ☐ No

Please note:

Only the patients first name or initials will be used, never the full name

Financial Discloser: I understand that the practice is not receiving compensation for the use of the patient's photo.

Refusal to Sign: I understand that the refusal to sign part or all of the Authorization will in no way affect the patient's treatment

Certification:

☐ I certify that I am the authorized representative for the patient. My relationship to the patient is:

_____

☐ I certify that I am the patient

Signature: _____ Date: _____

Witness: _____ Date: _____