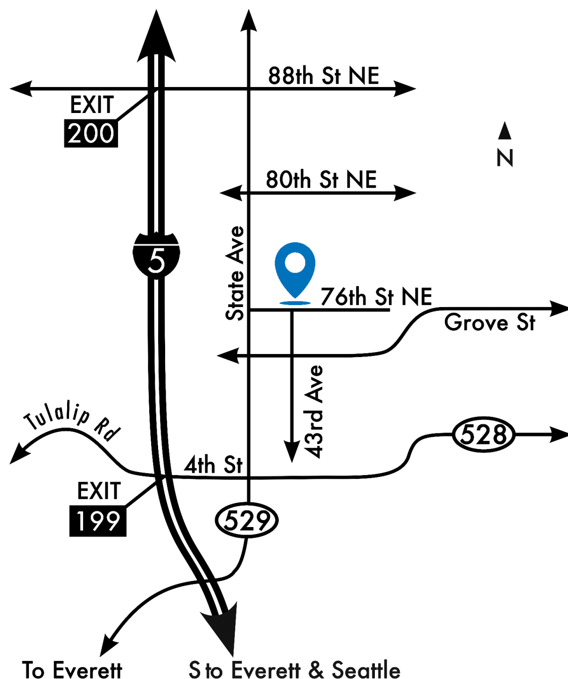
Welcome! You have definitely found the right place! At Marysville Orthodontics, we love creating beautiful and healthy smiles. We pride ourselves on caring for our patients like we would our own family. Our goal is to provide you with excellent orthodontic care, superior service, and wonderful treatment results!

Thank you for selecting our office! As our gift to you, our new patient exam, x-rays, photos, and consultation are complimentary. This first visit will take about an hour where you will receive a tour of our state-of-the art office and meet our friendly team. We will take digital x-rays and photos and will perform a thorough examination and review your clinical diagnosis. We will be sure to explain in detail any treatment recommendations that will best benefit you.

Included with this letter are new adult patient questionnaire, health history form and map of our location. Please complete the forms and bring them with you to your appointment.

The entire team at Marysville Orthodontics is excited about meeting you for your complimentary consultation. If you have any questions, please give us a call at 360-653-4114.



Your Best Smile Starts Here.

Sincerely,

Robert C. Lee, DDS, PhD, MSD
Board Certified Orthodontist
Specialists in Orthodontics and
Dentofacial Orthopedics

360-653-4114 4305 76th Street NE, Marysville, WA 98270 team@orthomarysville.com

ADULT PATIENT INFORMATION

Today's Date__________________

Patient's Name ____ Preferred Name__________________
Last First Middle

Home Address____
Street City State Zip

Cell # ________________________ Birthdate ________________ Sex ___ Age ___ SS # ________________________

Email __________________________________ Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

How did you hear about us? ☐Friend/Family ☐Dentist/Healthcare Professional ☐Website/Internet ☐Facebook ☐Other

Whom may we thank for referring you to our office?____

EMERGENCY CONTACT

Name ______________________________________ Cell #___________________ Relationship __________________

Address ____ Email ___________________________

EMPLOYMENT INFORMATION

Employer ___________________________________ Occupation_____________________ # Years employed ________

Bus. Address ____ Work # ___________________

If another person will be helping with this account, please provide his/her information below:

Name ______________________________________ Cell #___________________ Relationship __________________

Email __________________________________ Birthdate ________________ SS # _____________________________

Employer ___________________________________ Occupation_____________________ # Years employed ________

Bus. Address ____ Work # ___________________

DENTAL INSURANCE INFORMATION

Subscriber's Name_________________________________ Birthdate ______________ SS # or ID # _______________

Insurance Company _________________________ Group #_________________ Phone #________________________

Insurance Co. Address ____

Do you have dual coverage? ☐Yes ☐No *If yes:*

Subscriber's Name_________________________________ Birthdate ______________ SS # or ID # _______________

Insurance Company _________________________ Group #_________________ Phone #________________________

Insurance Co. Address ____

MEDICAL HISTORY

Physician ____________________ Date of Last Visit __________ Reason ____________________

Address ____ Phone ____________________

☐Yes ☐No Are you taking any medication? ____________________

☐Yes ☐No Do you require any antibiotic pre-medication prior to dental visits? ____________________

☐Yes ☐No Do you take, or have you taken Fosamax or Bisphosphonate? ____________________

☐Yes ☐No Do you have a history of a major illness? ____________________

☐Yes ☐No Have you had any operations? ____________________

☐Yes ☐No Have you ever been involved in a serious accident?____________________

☐Yes ☐No Have you ever smoked or chewed tobacco?____________________

☐Yes ☐No Do you use controlled substances?____________________

Female Patients only:

☐Yes ☐No Are you pregnant or trying to get pregnant? ____________________

☐Yes ☐No Do you take birth control pills?____________________

Are you allergic to any of following? ☐Penicillin ☐Acrylic ☐Metal ☐Latex ☐Local Anesthetics ☐Other ____________________

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Bone Disorders	Heart Murmur	Pneumonia
ADD/ADHD	Congenital Heart Defect	Hepatitis/Liver problems	Prolonged Bleeding
Anemia	Diabetes	Herpes	Radiation/Chemotherapy
Anxiety Disorder	Dizziness	High Blood Pressure	Rheumatic Fever
Arthritis	Epilepsy	HIV/AIDS	Tuberculosis
Asthma or Hayfever	Gastrointestinal Disorders	Kidney problems	Tumor or Cancer
Autism	Heart Problems	Nervous Disorders	Ulcer or Acid Reflux

Are there any medical conditions we have not discussed that you feel we should be aware of?____________________

____

DENTAL HISTORY

General Dentist____________________ Date of Last Visit __________ Reason ____________________

Address ____ Phone ____________________

Other Dental Specialists ____________________ Date of Last Visit __________ Reason ____________________

Address ____ Phone ____________________

Approximate date of your last cleaning____________________Do you brush daily? ☐Yes ☐No Floss daily? ☐Yes ☐No

What concerns do you have about your teeth? ____________________

☐Yes ☐No Do you like your smile? If no, why not? ____________________

☐Yes ☐No Have you ever had an orthodontic treatment before? If yes, when? ____________________

☐Yes ☐No Have you had an orthodontic consultation? If yes, what was the reason for not starting treatment? ____________________

____

Have you ever had or experienced any of the following?

☐Yes	☐No	Problems with previous dental treatment	☐Yes	☐No	Bleeding gum
☐Yes	☐No	Missing or extra permanent teeth	☐Yes	☐No	Lost or chipped any teeth
☐Yes	☐No	Trauma to the face, mouth, teeth or jaw(s)	☐Yes	☐No	Slow healing sores in or around the mouth
☐Yes	☐No	Mouth-breathing habit	☐Yes	☐No	Thumb or tongue habit
☐Yes	☐No	Pain in jaw joint, jaw clicking, popping or locking	☐Yes	☐No	Difficulty closing lips
☐Yes	☐No	Grinding or clenching teeth	☐Yes	☐No	Sleep apnea

I understand that credit bureau reports may be obtained. If necessary, I authorize Marysville Orthodontics to access my records from other health professionals. I acknowledge that I am responsible for all charges incurred regardless of insurance benefits or prearranged agreements. I, the undersigned, assign directly to Marysville Orthodontics all insurance benefits, otherwise payable to me for services rendered. I also hereby authorize Marysville Orthodontics to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes made in my medical or dental health.

____ ____________________

Signature Date

PRIVACY CONSENT

This form is optional under the new patient privacy regulations recently issued by the United States Department of Health and Human Services. We have elected to use this form. Prior to commencing your orthodontic treatment, you should review, sign and date this form.

- Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure).
- You have the right to review our office's privacy notice prior to signing this Consent, a copy of which was given to you with this Consent.
- You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request.
- We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.
- You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

Thank you for your cooperation. Please let us know if you have any questions.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosure described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health information to the person(s) indicated below:

Please circle

ANY MEMBER OF MY IMMEDIATE FAMILY	YES	NO
SPOUSE ONLY	YES	NO
OTHER (please specify) ________________________________	YES	NO

PATIENT ACKNOWLEDGEMENT

This Privacy Notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please contact our office. Thank you.

I hereby acknowledge that I have received and reviewed a copy of the Notice of Privacy Practices.

______________________________	______________
Responsible Party Signature	Date
______________________________	______________
Print Name	Relationship to Patient

AUTHORIZATION TO RELEASE MEDIA

This Authorization is required by the privacy regulations recently promulgated by the United States Department of Health and Human Services.

I hereby authorize Marysville Orthodontics or any of their assignees to disclose photographs, x-rays, study models, videos of the following patient's teeth, jaws and face as approved below:

Patient Name ______________________________ Birthdate ________________

I understand that the photographs, x-rays, study models, videos and comment cards will be used as a record of my care, and may be used for communication with other health professionals, educational publications (i.e., dental and scientific journals), educational lectures, research and/or practice marketing purposes (i.e., website publication, Facebook posts, etc).

I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these media materials.

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

☐Yes ☐No May your picture and video be displayed on the **office website, Facebook, Instagram and other social media accounts, and/or within the office** for the purpose of informing patients of the positive outcome we have achieved?

☐Yes ☐No May your picture and video be displayed on the **office website, Facebook, Instagram and other social media accounts, and/or within the office** if he/she is a contest prize winner?

☐Yes ☐No May your record including photographs be used for the purpose of **professional consultations, research, education or publication in professional journals**?

Please note:

- I understand that the practice is not receiving compensation from anyone for use of the patient's photo.
- This Authorization will not expire.
- I understand that refusal to sign part or all of this Authorization will in no way affect the patient's treatment.
- You have the right to revoke this Authorization at any time in writing. However, your revocation will not be effective to the extent that this Authorization has been relied on. I understand, however, that Marysville Orthodontics cannot guarantee my complete privacy in the event my image or likeness is used by third parties.
- The information used or disclosed per this Authorization may be subject to re-disclosure by the recipient(s), and thus, no longer protected by the privacy rules.

I have read the foregoing in its entirety and understand its terms.

______________________________ ________________
Responsible Party Signature Date

______________________________ ________________
Print Name Relationship to Patient