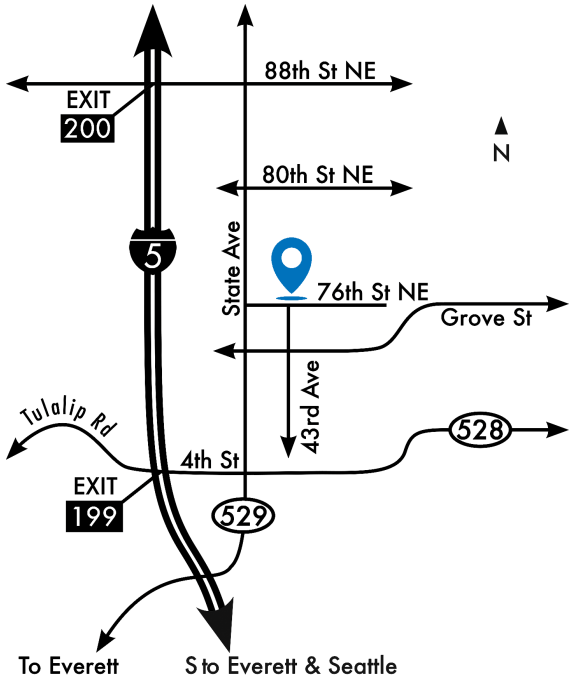
MARYSVILLE
orthodontics

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 child 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 and your child for your child's 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

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CHILD 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 _____ School _____ Grade _____

Hobbies/Sports _____

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? _____

PARENT/GUARDIAN INFORMATION

Marital Status: ☐Married ☐Separated ☐Divorced ☐Widowed ☐Other _____

Patient lives with: ☐Both parents ☐Father ☐Mother ☐Other _____

☐Father ☐Stepfather ☐Guardian ☐Other_____	☐Mother ☐Stepmother ☐Guardian ☐Other_____
Name _____	Name _____
Address _____	Address _____
City/State/Zip _____	City/State/Zip _____
Cell # _____ Work # _____	Cell # _____ Work # _____
Email _____	Email _____
SS# _____ Birthdate _____	SS# _____ Birthdate _____
Occupation _____ # Years employed ___	Occupation _____ # Years employed __
Employer _____	Employer _____
Bus. Address _____	Bus. Address _____

EMERGENCY CONTACT

Name _____ Cell Phone _____ Relationship _____

Address _____ Email _____

DENTAL INSURANCE INFORMATION

Subscriber's Name _____ Birthdate _____ SS # or ID # _____

Insurance Company _____ Group # _____ Phone # _____

Insurance Co. Address _____

Does your child 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 Is your child taking any medication? _____

☐Yes ☐No Does your child require any antibiotic pre-medication prior to dental visits? _____

☐Yes ☐No Does your child have a history of a major illness?_____

☐Yes ☐No Has your child had any operations?_____

☐Yes ☐No Has your child ever been involved in a serious accident? _____

☐Yes ☐No Has puberty begun? If yes, when? _____

Female Patients only:

☐Yes ☐No Has menstruation started? If yes, when?_____

☐Yes ☐No Does your child take birth control pills? _____

☐Yes ☐No Is your child pregnant or could be pregnant?_____

Is your child allergic to any of following? ☐Penicillin ☐Acrylic ☐Metal ☐Latex ☐Local Anesthetics ☐Other _____

Circle any of the medical conditions below that your child has had or currently has.

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/Pediatric Dentist _____ Date of Last Visit _____ Reason _____

Address _____ Phone _____

Approximate date of your child's last cleaning _____ Does your child brush daily? ☐Yes ☐No Floss daily? ☐Yes ☐No

What concerns do you have about your child's teeth? _____

☐Yes ☐No Is your child sensitive or self-conscious about his/her teeth? _____

☐Yes ☐No Has your child ever had an orthodontic treatment before? If yes, when? _____

☐Yes ☐No Has your child had an orthodontic consultation? If yes, what was the reason for not starting treatment? _____

_____

Has your child 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	Snoring at night	☐Yes	☐No	Speech problems
☐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

Height of parents: Dad _____ Mom _____

I understand that credit bureau reports may be obtained. If necessary, I authorize Marysville Orthodontics to access my child's 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 child's 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 child's medical or dental health.

Parent/Guardian Signature	Relationship to Patient	Date

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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

MARYSVILLE orthodontics

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 _____