

15446 Bel-Red Rd. Ste. 310  
Redmond, WA 98052 Tel:  
(425) 747-9210  
Fax: (425) 746-7486



**lake hills orthodontics**  
wisanu charoenkul, dds ms

## WELCOME!

So that we might become better acquainted, please complete the following:

### Adult Patient Information

**Patient's Name:** \_\_\_\_\_ **Email:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_  
**Mailing Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_  
**Birth Date:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Male**  **Female**  **School:** \_\_\_\_\_  
**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_  
**Email:** \_\_\_\_\_ **Name of Spouse (if married):** \_\_\_\_\_  
**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_ **Years Employed:** \_\_\_\_\_  
**Dentist:** \_\_\_\_\_ **Date of Last Dental Check-Up** \_\_\_\_\_  
**Whom may we thank for referring you to our office?** \_\_\_\_\_

### Responsible Party Information

**Self**  **Spouse**  **Other** **Name:** \_\_\_\_\_ **Single**  **Married**  **Divorced**  **Separated**   
**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_ **Years** \_\_\_\_\_  
**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_  
**Social Security #** \_\_\_\_ - \_\_\_\_ - \_\_\_\_ **Birth Date:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_  
**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_ **Years Employed:** \_\_\_\_\_

### Dental Insurance Information

**Policy Holder's Name:** \_\_\_\_\_ **Birth Date** \_\_\_\_\_ **SSN #** \_\_\_\_\_  
**Insurance Company:** \_\_\_\_\_ **ID #** \_\_\_\_\_ **Group #** \_\_\_\_\_  
**Insurance Co. Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**2nd Insured's Name:** \_\_\_\_\_ **Birth Date** \_\_\_\_\_ **SSN #** \_\_\_\_\_  
**Insurance Company:** \_\_\_\_\_ **ID #** \_\_\_\_\_ **Group #** \_\_\_\_\_  
**Insurance Co. Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Phone #** \_\_\_\_\_

I authorize and request my insurance company to pay directly to "Lake Hills Orthodontics – Wisanu Charoenkul, DDS MS" all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that where appropriate, credit bureau reports may be obtained and I agree to pay for attorney fees and other costs of collection in the event it becomes necessary to use attorney services to secure payment of this account.

On occasion, Lake Hills Orthodontics will display photos of similar cases to prospective patients seeking outcomes of similar cases. I hereby give permission for use in the following instance. We will never use your photo in public displays without specific permission from you beforehand (i.e. Internet, Newspaper).

**Signature** \_\_\_\_\_

**Relationship to Patient** \_\_\_\_\_

**Print Name** \_\_\_\_\_

Please turn over for more on the back...

**Medical History Adult**

Patient's Name: \_\_\_\_\_

Name of your physician: \_\_\_\_\_

Date of last exam \_\_\_\_\_

1. Are you in good health?  Yes  No
2. Do you have a health problem?  Yes  No If yes, please explain \_\_\_\_\_
3. Do you have allergies to medications, medical products (latex) or to the environment (dust mites, pollen, etc.)?  
 Yes  No If yes, please list \_\_\_\_\_
4. Please list any current prescription medications you are taking: \_\_\_\_\_
5. Have you been treated by a physician for any of the following conditions? (Check any that apply)
 

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Delayed Growth	<input type="checkbox"/> Bone Disorders	<input type="checkbox"/> Anemia
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Prolonged Bleeding	<input type="checkbox"/> Fainting/Dizziness	<input type="checkbox"/> Heart
<input type="checkbox"/> Kidney or Liver Involvement	<input type="checkbox"/> Epilepsy (convulsions)	<input type="checkbox"/> Rheumatic Trouble	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Learning Disabilities	<input type="checkbox"/> Metal Allergies (i.e. nickel)	<input type="checkbox"/> Emotional Issues	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Frequent Sore Throats	<input type="checkbox"/> Tonsils/Adenoids Removed	<input type="checkbox"/> Joint Prosthesis	<input type="checkbox"/> Earaches
<input type="checkbox"/> Compromised Immune System	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Joint Swelling	<input type="checkbox"/> Lupus
6. Are you a smoker?  Yes  No For how long? \_\_\_\_\_ @ \_\_\_\_\_ packs/day.
7. (Female) Do you take birth control pills?  Yes  No Are you pregnant?  Yes  No

**Dental History**

What is your chief concern(s)? \_\_\_\_\_

**Are you interested in (please indicate all that apply)**

- |                                      |  |   |
|--------------------------------------|--|---|
| <input type="checkbox"/> Information | <input type="checkbox"/> Treatment now | <input type="checkbox"/> Clarification of previous or conflicting information |
|--------------------------------------|--|---|
1. Have you had any injuries or operations to your face, mouth, or teeth?  Yes  No  I don't know
  2. Do you know of any missing or extra permanent teeth?  Yes  No  I don't know
  3. Has any previous orthodontic treatment been rendered?  Yes  No  I don't know
  4. Do you have any speech problems?  Yes  No  I don't know
  5. Do you suffer from any jaw joint problems such as pain, clicking or popping?  Yes  No  I don't know
  6. Do you grind or clench your teeth during the day or night?  Yes  No  I don't know
  7. Inability to open mouth wide or move jaw normally?  Yes  No  I don't know
  8. Teeth difficult to clean?  Yes  No  I don't know
  9. Awareness of any gum or bone problems around teeth?  Yes  No  I don't know
  10. Concerned about the appearance of your teeth?  Yes  No  I don't know
  11. Concerned about the appearance of your face and/or jaw structure?  Yes  No  I don't know

What types of braces are you interested in?  Metal  Ceramic  Clear Aligners  I didn't know there were choicesYour attitude toward orthodontic treatment:  Very Motivated  Will Cooperate if needed  Not Motivated

Comments: \_\_\_\_\_

I understand that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes. I authorize the dental staff to perform the necessary dental services. For training and quality purposes the initial exam will be recorded. I give permission for the use of orthodontic records, including photographs, made in the process of examinations, treatment and retention for purposes of professional consultations, research, education, or for publication in professional journals.

Signature \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Patient Name \_\_\_\_\_



## HIPAA

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Lake Hills 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.

Lake Hills Orthodontics reserves the right to change the privacy practices that are described in the 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 to me.

### ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement 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"/> NO
SPOUSE ONLY	<input type="checkbox"/> YES	<input type="checkbox"/> NO
OTHER (Please Specify) _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Name of Patient (Please Print): \_\_\_\_\_

Patient Signature (Parent if Minor): \_\_\_\_\_

Date: \_\_\_\_\_



15446 Bel-Red Road, Suite 310 Redmond, WA 98052  
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## **STATEMENT OF PRIVACY PRACTICES**

Our office is dedicated to protecting our patients' privacy rights and the confidential information entrusted to us. Each employee's commitment to ensuring your health information is never compromised is a core principle of our practice. We may, from time to time, amend our privacy policies and practices, but we 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 health 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 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 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.

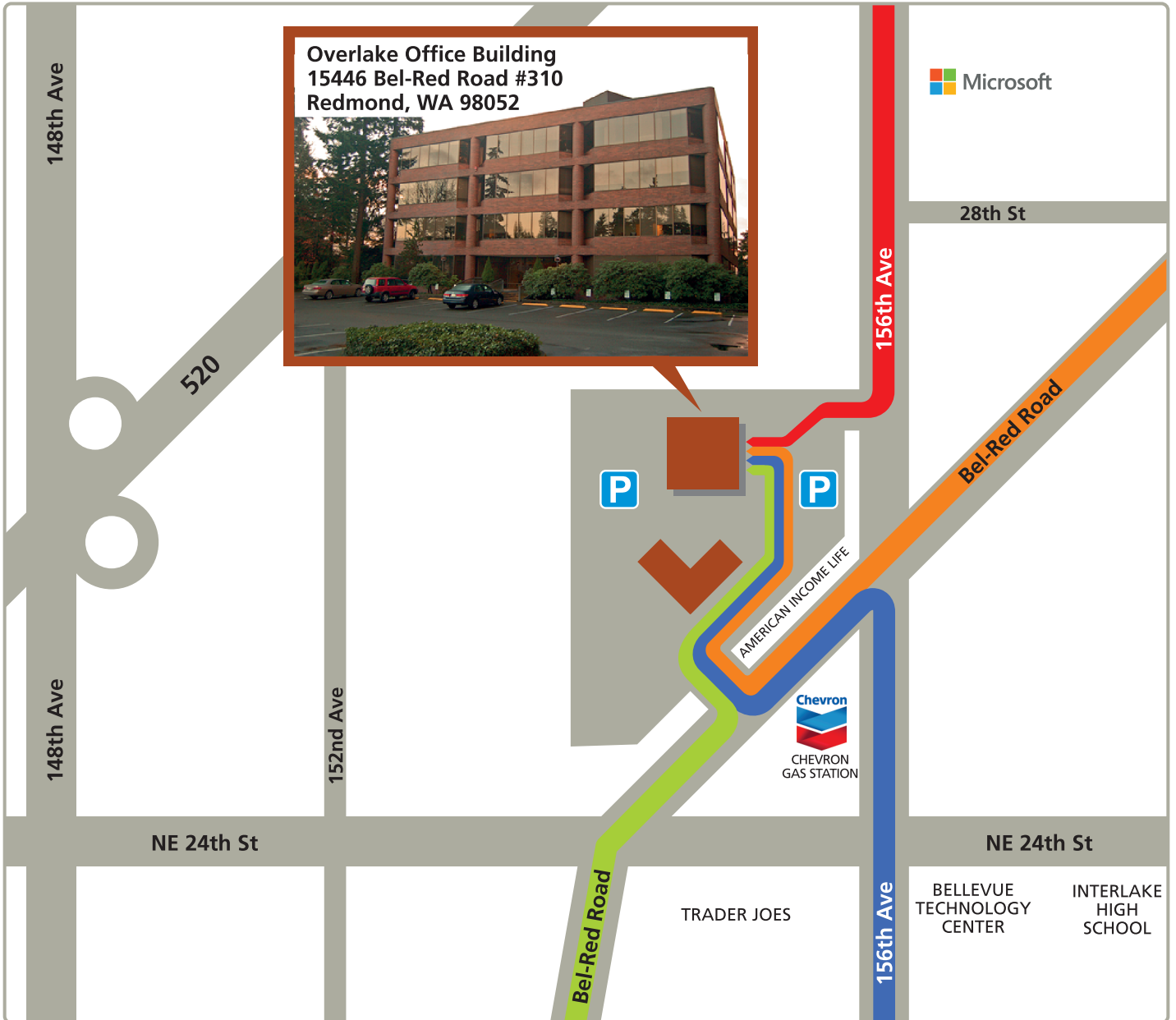
### **Substance Use Disorder Information**

Records related to substance use disorder diagnosis, treatment, or referral are protected under federal law (42 CFR Part 2). We may use and disclose such information for treatment, payment, and healthcare operations only with your prior written consent, unless otherwise permitted by law. Once disclosed with your consent, the information may be redisclosed as permitted by applicable law, including HIPAA. You may revoke your consent at any time, except where action has already been taken.

### **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 our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.



**Traveling South on 156th Ave (from Microsoft Campus)**

After passing 28th Street, and just before the intersection of 156th and Bel-Red turn right into the front parking lot of 4 story red brick building. There is additional parking to the rear of the building.

**Traveling West on Bel-Red Road (from Marymoor Park/Redmond)**


Just after the intersection of Bel-Red Road and 156th, the driveway entrance will be on your right immediately after the American Income Life sign. Proceed to your right into the front parking lot of the 4 story red brick building. There is additional parking to the rear of the building.

**Traveling East on Bel-Red Road (from Bellevue)**

Enter the left turn lane as if you would turn left onto 156th Ave. Before reaching the intersection, there is a break in the road divider where you will turn left into the driveway next to the American Income Life sign. Proceed to your right into the front parking lot of the 4 story red brick building. There is additional parking to the rear of the building.

**Traveling North on 156th Ave (from Bellevue Crossroads)**

Turn left onto Bel-Red Road at the red light, the driveway entrance will be on your right immediately after the American Income Life sign. Proceed to your right into the front parking lot of the 4 story red brick building. There is additional parking to the rear of the building.

 There is free visitor parking available in either the front or rear parking lots.

 We are located within the four story red brick building with round columns.

**FLOOR 3 | SUITE 310** Once inside the building, take the elevator to the third floor and turn right.