



lake hills orthodontics

wisanu charoenkul, dds ms

14810 Lake Hills Boulevard • Bellevue • WA • 98007

425.747.9210 www.lakehillsortho.com

New Patient Information

A B C

Patient's Name: _____ Sex: M / F
Last First Middle

Address: _____
Street City State ZIP

Birthdate: _____ Age: _____ SSN#: _____ Home Phone: () _____

Contact Email _____ School: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend or relative Dental Office
 Internet Yellow Pages Newspaper School Work Other _____

Name of person or office referring you to our practice: _____

Responsible Party Information

Primary Responsible Party: _____ SSN#: _____
Same as above Last First Middle

Address: _____
Street City State ZIP

How long at this address? _____ Home Phone: _____ Work Phone _____

Birth date: _____ Relationship to Patient: _____ Spouse's Name: _____

Employer: _____ Occupation: _____ Yrs Employed: _____

Insurance Plan Name: _____ Member ID # _____ Group #: _____

Address: _____ Phone #: _____

Secondary Responsible Party: _____ SSN#: _____
Same as above Last First Middle

Address: _____
Street City State ZIP

How long at this address? _____ Home Phone: _____ Work Phone _____

Birth date: _____ Relationship to Patient: _____ Spouse's Name: _____

Employer: _____ Occupation: _____ Yrs Employed: _____

Insurance Plan Name: _____ Member ID # _____ Group #: _____

Address: _____ Phone #: _____

Emergency Contact

In case of emergency who should be notified? _____ Phone: _____

Relationship to patient: _____ Address: _____

(OVER)

Authorization and Release

I have read and answered the above questions to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in the future. I authorize the dental staff to perform the necessary dental services. 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.

Patient Signature (Parent if minor)

Date

I authorize and request my insurance company to pay directly to "Lake Hills Orthodontics – Wisanu Chroenkul, DDS MS PC" 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 doctor 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.

Patient Signature (Parent if minor)

Date

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. 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 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

Patient Signature (Parent if minor)

Date