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:

Child Patient Information (≤18yo)

Patient's Name: _____ Email:_____ Today's Date:
Mailing Address: _____ City: _____ State: _____ Zip: _____
Birth Date:_____ Age: _____ Male □ Female □ Grade: _____ School: _____
Dentist: _____ Date of Last Dental Check-Up _____
Who will be attending appointments with the patient? _____
Whom may we thank for referring you to our office? _____

Responsible Party Information

Name: _____ Relationship to patient: _____ 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: _____

Name: _____ Relationship to patient: _____ 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 Child

Patient's Name: _____

Name of your physician: _____ Date of last exam _____

1. Is the patient in good health? □ Yes ■ No
2. Does the patient have a health problem? □ Yes ■ No If yes, please explain _____
3. Does the patient 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: _____
5. Have the patient been treated by a physician for any of the following conditions? (Check any that apply)

□ Diabetes	□ Delayed Growth	□ Bone Disorders	□ Anemia
□ Mitral Valve Prolapse	□ Prolonged Bleeding	□ Fainting/Dizziness	□ Heart
□ Kidney or Liver Involvement	□ Epilepsy (convulsions)	□ Rheumatic Trouble	□ Thyroid
□ Learning Disabilities	□ Metal Allergies (i.e. nickel)	□ Emotional Issues	□ Arthritis
□ Frequent Sore Throats	□ Tonsils/Adenoids Removed	□ Joint Prosthesis	□ Earaches
□ Compromised Immune System	□ Rheumatoid Arthritis	□ Joint Swelling	□ Lupus

Over 15yo:

6. Is the patient a smoker? □ Yes ■ No For how long? _____ @ _____packs/day.
7. Does the patient take birth control pills? □ Yes ■ No Is the patient pregnant? □ Yes ■ No

Dental History

What is your chief concern(s):_____

_____

Are you interested in (please indicate all that apply)

□ Information □ Treatment now □ Clarification of previous or conflicting information

1.	Have you had any injuries or operations to the 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.	Does the patient have any speech problems?	□ Yes	☑ No	□ I don't know
5.	Does the patient suffer from any jaw joint problems such as pain, clicking or popping?	□ Yes	☑ No	□ I don't know
6.	Have you observed your child has any habits?	☐ Thumb/finger sucking	☐ Mouth breathing	☐ Tongue thrust
7.	While sleeping does your child snore loudly?	□ Yes	☑ No	□ I don't know
8.	Does your child breathe tend to breathe through their mouth during the day?	□ Yes	☑ No	□ I don't know
9.	Does your child have a problem with sleepiness during the day?	□ Yes	☑ No	□ I don't know
10.	Has your child been diagnosed with ADHD?	□ Yes	☑ No	□ I don't know

Jaw Growth

In some instances, the ability of Dr. Charoenkul to help guide the growth amount and direction of your child's jaw may be critical to the success of the orthodontic treatment plan. In order to determine your child's jaw growth potential, please answer the following:

Do you feel he/she is still growing? ☐ Yes ☐ No **GIRLS:** Has she started menstruation (monthly periods)? ☐ Yes ■ No
Patient's current height: _____ **BOYS:** Has voice changed? ■ Yes ☐ No Started to shave? ■ Yes ☐ No
Mother's height: _____ Father's height: _____ Approximately when did these changes begin? _____

What types of braces are you interested in? □ Metal □ Ceramic ■ Clear Aligners ■ I didn't know there were choices

Your 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 _____

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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 indicted below.

ANY MEMBER OF MY IMMEDIATE FAMILY	☐ YES	☐ NO
SPOUSE ONLY	☐ YES	☐ NO
OTHER (Please Specify)_____	☐ YES	☐ NO

Name of Patient (Please Print): _____

Patient Signature (Parent if Minor): _____ Date: _____

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STATEMENT OF PRIVACY PRACTICES

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices but 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 you r 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.

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.

MAP

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☎ 425-747-9210

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.

P — 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.