PLEASE PRINT

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE ☐ YES ☐ NO	INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE

SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT	SUBSCRIBER'S BIRTHDAY	SUBSCRIBER'S SSN / ID #

GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER'S ADDRESS

SECONDARY COVERAGE ☐ YES ☐ NO	INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE

SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT	SUBSCRIBER'S BIRTHDAY	SUBSCRIBER'S SSN / ID #

GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER'S ADDRESS

RELEASE INFORMATION

YOU MAY DISCUSS MY HEALTHCARE WITH

	YES	NO	OTHERS (PLEASE PRINT)
Health Care Providers			1.
Insurance Companies			2.

CONFIRMATIONS

DO YOU PREFER A CONFIRMATION CALL

No, it is unnecessary ☐ Yes, it is a helpful reminder ☐

ASSIGNMENT & RELEASE

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for this claim. I authorize that my records can be used by the doctor if he so determines. In consideration of the services rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy.

I consent to making of videotapes, photographs, and x-rays before, during, and after treatment, and to use the same by the doctor in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

SIGNATURE - PATIENT / GUARDIAN	DATE

WITNESS SIGNATURE	DATE

PLEASE PRINT

CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S LEGAL NAME LAST, FIRST MI	DATE OF BIRTH	SEX	SOCIAL SECURITY #

PREFER TO BE CALLED	HOME PHONE #	CELL PHONE #

PATIENT'S ADDRESS STREET APT# CITY STATE ZIP	E-MAIL

MARITAL STATUS S M W D UNDER AGE 18	PATIENT'S / GUARDIAN'S EMPLOYER	OCCUPATION

WORK ADDRESS STREET APT# CITY STATE ZIP	WORK PHONE #

SPOUSE'S NAME LAST, FIRST MI	SPOUSE'S EMPLOYER	OCCUPATION

SPOUSE'S WORK ADDRESS STREET APT# CITY STATE ZIP	WORK PHONE #

OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE	WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?

EMERGENCY CONTACT INFORMATION

PERSON WE MAY CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)

NAME	RELATIONSHIP

HOME PHONE #	WORK PHONE #	CELL PHONE #

REQUEST FOR CONFIDENTIAL COMMUNICATION

AS MY DENTAL CARE PROVIDER, YOU MAY DO THE FOLLOWING WITH MY PERMISSION:

	YES	NO
Contact me at home		
Contact me via cell phone		
Contact me at work		
Contact me via e-mail		
Leave messages on my home voicemail / answering machine		
Leave messages on my cell phone voicemail		
Leave messages on my work voicemail / answering machine		

DENTAL HISTORY

Name_____ Nickname_____ Age_____
Referred by_____How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist _____How long have you been a patient?_____Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ ☐ ☐
2. Have you had an unfavorable dental experience? _____ ☐ ☐
3. Have you ever had complications from past dental treatment? _____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ ☐ ☐
6. Have you had any teeth removed? _____ ☐ ☐

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? _____ ☐ ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ ☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ☐ ☐
10. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
11. Have you ever experienced gum recession? _____ ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ☐ ☐
13. Have you experienced a burning sensation in your mouth? _____ ☐ ☐

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? _____ ☐ ☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ☐ ☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ☐ ☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ ☐ ☐
18. Do you have grooves or notches on your teeth near the gum line? _____ ☐ ☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ ☐ ☐
20. Do you frequently get food caught between any teeth? _____ ☐ ☐

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____ ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ ☐ ☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ☐ ☐
25. Are your teeth crowding or developing spaces? _____ ☐ ☐
26. Do you have more than one bite and squeeze to make your teeth fit together? _____ ☐ ☐
27. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ ☐
28. Do you clench your teeth in the daytime or make them sore? _____ ☐ ☐
29. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ ☐ ☐
30. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

SMILE CHARACTERISTICS

31. Is there anything about the appearance of your teeth that you would like to change? _____ ☐ ☐
32. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
33. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ ☐
34 Have you been disappointed with the appearance of previous dental work? _____ ☐ ☐

Patient's Signature _____ Date_____

Doctor's Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury_____	☐	☐
2. an allergic reaction to		
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ other _____		
3. heart problems, or cardiac stent within the last six months __	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. artificial prosthesis (heart valve or joints) _____	☐	☐
8. rheumatic or scarlet fever_____	☐	☐
9. high or low blood pressure_____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. tuberculosis, measles, chicken pox_____	☐	☐
15. asthma_____	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c =_____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive disorders (i.e. celiac disease, gastric reflux) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __	☐	☐
27. arthritis, rheumatoid arthritis, lupus _____	☐	☐
28. glaucoma_____	☐	☐
29. contact lenses _____	☐	☐
30. head or neck injuries _____	☐	☐
31. epilepsy, convulsions (seizures) _____	☐	☐
32. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
33. viral infections and cold sores _____	☐	☐
34. any lumps or swelling in the mouth_____	☐	☐
35. hives, skin rash, hay fever_____	☐	☐
36. STI / STD _____	☐	☐
37. hepatitis (type ___) _____	☐	☐
38. HIV / AIDS _____	☐	☐
39. tumor, abnormal growth_____	☐	☐
40. radiation therapy_____	☐	☐
41. chemotherapy, immunosuppressive_____	☐	☐
42. emotional problems _____	☐	☐
43. psychiatric treatment_____	☐	☐
44. antidepressant medication _____	☐	☐
45. alcohol / street drug use _____	☐	☐
ARE YOU:		
46. presently being treated for any other illness _____	☐	☐
47. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____	☐	☐
48. taking medication for weight management (i.e. fen-phen)	☐	☐
49. taking dietary supplements_____	☐	☐
50. often exhausted or fatigued _____	☐	☐
51. experiencing frequent headaches_____	☐	☐
52. a smoker, smoked previously or use smokeless tobacco _	☐	☐
53. considered a touchy person _____	☐	☐
54. often unhappy or depressed_____	☐	☐
55. FEMALE - taking birth control pills _____	☐	☐
56. FEMALE - pregnant _____	☐	☐
57. MALE - prostate disorders _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

_____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

FINANCIAL POLICY

Excellent professional doctor/patient relations depend on mutual respect, trust and understanding. The fees we charge for services rendered are set according to the level of advanced dentistry. Our dental fee is unique because it is all inclusive—includes any commercial laboratory charges, use of trained auxiliary personnel, quality materials, treatment facilities, post-graduate training and the doctor's time, skill, care and judgment. We always invite your questions.

You will be provided with a complete description of a treatment plan and an estimate of the total fee. If you undertake the treatment plan, you will be responsible for payment of the fee regardless of your dental insurance benefits. If, during the course of treatment, we find additional treatment is needed, we will discuss the situation along with any additional costs prior to proceeding.

The following payment options are as follows*:

- Full payment by cash, check or credit card on the day of service
- Financing through one of our many financial institutions

For patients with dental insurance, payment is expected at the time of service by way of the above options. We now have the ability to send your claim electronically expediting the reimbursement process. As a courtesy to all our clients, insurance payments and out-of-pocket ***estimates*** are provided upon request. This is not a guarantee for payments, benefits or coverage.

*Washington Dental Service/Delta Dental, Premera and Regence patients will be required to make any estimated co-payments at the time of the visit. We cannot offer any pre-payment savings for patients with these insurance participants.

If you schedule an appointment for major restorative treatment, pre-payment is required, regardless of insurance coverage.

Unpaid balances accrue finance fees of 1.50% after 30 days regardless of insurance benefits. ***Appointment cancellation/rescheduling less than 48 hours notice for hygiene visits will incur a $75 fee. Cancellations or rescheduling appointments on extended visits for major restorative treatment may forfeit partial prepayment fee or $250, (whatever amount is less) if less than 48 hours notice provided.***

Overpayments and credit balances will be refunded at the patient's request after being processed and posted to the account. Credits may be applied to future dental treatment if desired.

I have read and understand the financial policies stated above.

Signed _____ Date _____

Kim Okamura DDS 11730 15th Ave NE Seattle WA 98125 206.362.3200 fax 206.362.0621
www.KimOkamuraDDS.com smile@kimokamuradds.com

STATEMENT OF PRIVACY PRACTICES

Dr. Kim Okamura
11730 15th Ave NE
Seattle WA 98125
206.362.3200
KimOkamuraDDS.com smile@kimokamuradds.com

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 dental 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 office and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your record is always protected. Our privacy policy and practices apply to all former, current and future patients; you can be confident your protected health information will never be improperly disclosed or released. Insurance companies will not receive any financial information other than their reimbursement information.

Collecting protected health information

We will only request personal information needed to provide our standard quality of dental care, implement payment activities, conduct normal dental practice operations and comply with the law. This may include your name, address, telephone numbers, 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 deemed necessary. Regardless of 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, text messages, email and postcards. Family members, and in some cases, others will have access to your PHI in the event of your death.

Patient rights

You have the right to request copies of your healthcare information: to request copies in a variety of formats; 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 requests must be in writing. We may charge for 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 US Department of Health and Human Services.

We thank you for being a patient at Kim Okamura DDS. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.