# Thank You For Selecting Our Dental Team

To help us meet all your health care needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

LINDA E. FUKUDA, DDS
Family Dentistry

## Patient Information (confidential)

Patient Number _____

Name _____ Date _____

SS#/SIN _____ Birth Date _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Email _____ Cell Phone _____

If Student, Name of School/College _____ City _____ State _____

Patient or Parent/Guardian's Employer _____ Work Phone _____ ☐ Full Time ☐ Part Time

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Where Did You Hear About Us? ☐ Word of Mouth ☐ Phone Book ☐ Walk By ☐ Internet ☐ Other _____

Person to Contact in case of Emergency _____ Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

## Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Drivers Licence # _____ Birth Date _____ Financial Institution _____

Employer _____ Work Phone _____ SS# _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ Visa ☐ MasterCard ☐ I wish to discuss the office's payment policy.

## Insurance Information

Name of Insured _____ Relationship to Patient _____

Birth Date _____ SS# _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID# _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your Deductible? _____ How much used? _____ Max. Annual Benefit _____

Do you have any additional Insurance? ☐ Yes ☐ No If yes, Complete the following

Name of Insured _____ Relationship to Patient _____

Birth Date _____ SS# _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID# _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your Deductible? _____ How much used? _____ Max. Annual Benefit _____

OVER PLEASE

## Patient Medical History

Physician _____ Office Phone _____ Date of last Exam _____

| | Yes | No |
|---|---|---|
| 1. Are you under medical treatment now? | ☐ | ☐ |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____ | ☐ | ☐ |
| 3. Are you taking any medication(s) including non-prescription medicine? If yes, please explain _____ | ☐ | ☐ |
| 4. Have you ever taken Fen-Phen/Redux? | ☐ | ☐ |
| 5. Have you ever taken Fosamax, Boniva, Actonel or any osteo-porosis or cancer medications containing bisphosphonates? | ☐ | ☐ |
| 6. Have you ever taken Viagra, Renvatio, Cialis or Levitra in the last 24 hours? | ☐ | ☐ |
| 7. Do you use tobacco? | ☐ | ☐ |
| 8. Do you use controlled substances? | ☐ | ☐ |
| 9. Are you wearing contact lenses? | ☐ | ☐ |
| 10. Do you have or have you had any of the following? | | |

| | Yes | No |
|---|---|---|
| 11. Are you allergic to or have had reactions to the following? | | |
| Local Anesthetics (e.g. Novocaine) | ☐ | ☐ |
| Penicillin or any other Antibiotics | ☐ | ☐ |
| Sulfa Drugs | ☐ | ☐ |
| Barbiturates | ☐ | ☐ |
| Sedatives | ☐ | ☐ |
| Iodine | ☐ | ☐ |
| Aspirin | ☐ | ☐ |
| Any Metals (e.g. nickel, mercury, etc.) | ☐ | ☐ |
| Latex Rubber | ☐ | ☐ |
| Other _____ | ☐ | ☐ |
| 12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? | ☐ | ☐ |
| 13. Women Only: | | |
| Are you pregnant or think that you may be pregnant? | ☐ | ☐ |
| Are you nursing? | ☐ | ☐ |
| Are you taking oral contraceptives? | ☐ | ☐ |

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| High Blood Pressure | ☐ | ☐ | Heart Disease | ☐ | ☐ | Chest Pains | ☐ | ☐ |
| Heart Attack | ☐ | ☐ | Cardiac Pacemaker | ☐ | ☐ | Easily Winded | ☐ | ☐ |
| Rheumatic Fever | ☐ | ☐ | Heart Murmur | ☐ | ☐ | Stroke | ☐ | ☐ |
| Swollen Ankles | ☐ | ☐ | Angina | ☐ | ☐ | Hay Fever/Allergies | ☐ | ☐ |
| Fainting/Seizures | ☐ | ☐ | Frequently Tired | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Asthma | ☐ | ☐ | Anemia | ☐ | ☐ | Radiation Therapy | ☐ | ☐ |
| Low Blood Pressure | ☐ | ☐ | Emphysema | ☐ | ☐ | Glaucoma | ☐ | ☐ |
| Epilepsy/Convulsions | ☐ | ☐ | Cancer | ☐ | ☐ | Recent Weight Loss | ☐ | ☐ |
| Leukemia | ☐ | ☐ | Arthritis | ☐ | ☐ | Liver Disease | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Joint Replacement or Implant | ☐ | ☐ | Heart Trouble | ☐ | ☐ |
| Kidney Disease | ☐ | ☐ | Hepatitis/Jaundice | ☐ | ☐ | Respiratory Problems | ☐ | ☐ |
| AIDS or HIV Infection | ☐ | ☐ | Sexually Transmitted Disease | ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ |
| Thyroid Problem | ☐ | ☐ | Stomach Troubles/Ulcers | ☐ | ☐ | Other _____ | ☐ | ☐ |

## Patient Dental History

Name of Previous Dentist _____ Date of Last Exam _____

Previous Dentist Location _____ Date of Last Cleaning _____

| | Yes | No |
|---|---|---|
| 1. Do your gums bleed while brushing or flossing | ☐ | ☐ |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | ☐ | ☐ |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | ☐ | ☐ |
| 4. Do you feel pain to any of your teeth? | ☐ | ☐ |
| 5. Do you have any sores or lumps in or near you mouth? | ☐ | ☐ |
| 6. Have you had any head, neck or jaw injuries? | ☐ | ☐ |
| 7. Have you ever experienced any of the following problems in your jaw? | | |
| Clicking | ☐ | ☐ |
| Pain (joint, ear, side of face) | ☐ | ☐ |
| Difficulty in opening or closing | ☐ | ☐ |
| Difficulty in chewing | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| 8. Do you have frequent headaches? | ☐ | ☐ |
| 9. Do you clench or grind your teeth? | ☐ | ☐ |
| 10. Do you bite your lips or cheeks frequently? | ☐ | ☐ |
| 11. Have you ever had any difficult extractions in the past? | ☐ | ☐ |
| 12. Have you ever had any prolonged bleeding following extractions? | ☐ | ☐ |
| 13. Have you had any orthodontic treatment? | ☐ | ☐ |
| 14. Do you wear dentures or partials? If yes, date of placement _____ | ☐ | ☐ |
| 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? | ☐ | ☐ |
| 16. Do you like your smile? | ☐ | ☐ |

## Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/ or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all service rendered on my behalf or my dependents.

X _____

Signature of Patient ( or parent or guardian if minor)

Doctor's Comments _____

_____

_____ Signature _____ Date _____

## Financial Arrangements and Dental Insurance

We are committed to providing you with the best possible dental care! If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been made and approved in advance by our staff. We accept cash, checks, Visa and Master Card. If you have dental insurance, we will be happy to help you process your insurance claim form. Any such request must be accompanied by a completed insurance claim form at each visit. You may pay us at the time of your visit or sign the claim form to have your insurance payments sent directly to us. For Major work, your portion of the financial responsibility for services is due at the time service is rendered.

Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1 ½ % per month. Charges may also be applied due to broken appointments, including those cancelled with less than 48 hours notice.

We will gladly discuss your proposed treatment and answer any questions related to your insurance. You must realize, however, that

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, therefore, covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "UCR" fees (defined as Usual, Customer and Reasonable for this region).
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasis as a dental care provider our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility. We realize that temporary financial problems may affect timely payment on your account. If such a problem does arise, we encourage you to contact us promptly for assistance in the management of your account.

_____ _____

(Patient or legal guardian's signature) (Date)

## Financial Arrangement and Agreement

I give Dr. Fukuda's office permission to charge my Visa, Master Card or Care Credit Card by phone, mail or in person. (This means if you call with your credit card number or write it on the bottom of your invoice, an authorized person of our office will have permission to process it without your signature).

If using Care Credit, you have read and fully understand *their* financial and payment agreement plan and agree to *their* terms and conditions.

_____ _____

(Patient or legal guardian's signature) (Date)

# NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the office manager.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

**By my signature below I acknowledge receipt of the Notice of Privacy Practices.**

| Patient or legally authorized individual signature | Date | Time |
|---|---|---|

| Printed name if signed on behalf of the patient | Relationship (parent, legal guardian, personal representative) |
|---|---|

This form will be retained in your medical record.

Last Update: 04/14/03

# LINDA E. FUKUDA, DDS
# PEGGY P. LEE, DDS, MSD, Ph.D
Family Dentistry

8119 Greenwood Ave. N.
Seattle, WA 98103
(206) 784-4800
www.LindaFukudaDDS.com


**Authorization to Release Records**

Patient Name:_____
Name of Previous Dentist: _____
City & State: _____
Telephone # of Previous Dentist:_____

Please release the following information related to my dental health:

Full mouth x-rays
Bitewing x-rays
Periodontal charting
Panoramic x-ray

Email to: info@lindafukudadds.com

Or

New Dentist (name, complete address, email and telephone#)

_____
_____
_____

I hereby release Dr. Linda Fukuda from any liability related to the disclosure of confidential information of the above mentioned patient.

Patient or Legal Guardian Signature: _____
Date: _____

Your insurance policy is a contract between you and your insurance company. Insurance policies vary, even within the same company. Your insurance company has the final say on what is covered and not covered under your policy. All questions about your coverage should be directed to your insurance company. As the patient and insured person, it is your responsibility to know your insurance and verify that you have coverage for the dental services you seek.

All services you receive here are transactions between you and your health care provider. If the services are not covered by your insurance, you may ultimately be responsible for the cost of these services.

**We appreciate your understanding.**