JAYNA SEKIJIMA, DDS

SHORELINE DENTIST

Welcome, and thank you for choosing us as your dental providers. Our intent is to earn the trust you have shown by choosing us as your dental office. Please help us by completing the following confidential form.

Patient Information

Date _____

Last Name _____ First Name _____ M.I. _____

By what name would you like us to call you? _____ Date of Birth _____ / _____ /_____

Preferred pronouns ☐ She/Her/Hers ☐ They/Them/Theirs ☐ He/Him/His ☐ Other: _____

Marital Status ☐ S ☐ M ☐ D ☐ W

Street Address _____ Home Phone _____

City/State/ZIP _____ Cell Phone _____

Email _____ Work Phone _____

Employer _____ Occupation _____

Responsible Party (If different from above)

Name _____ Relationship to Patient _____

Billing Street Address _____ Home Phone _____

Billing City/State/ZIP _____ Cell Phone _____

Email _____ Work Phone _____

Emergency Contact

Name _____ Relationship to the Patient _____

Phone Numbers H _____ C _____ W _____

How did you find out about our office?

_____

Insurance *(Information is usually listed on insurance card)*

Subscriber's Name _____ Relationship to the Patient _____

Subscriber's Date of Birth ____ / ____ / _____ □ Male □ Female SS# / ID _____

Insurance Company _____ Phone Number _____

Insurance Company PO Box _____ City _____ State _____ Zip_____

Employer _____ Group Number _____

Do you have a secondary insurance? □ Yes □ No If yes, Please complete the following:

Subscriber's Name _____ Relationship to the Patient _____

Subscriber's Date of Birth ____ / ____ / _____ □ Male □ Female SS# / ID _____

Insurance Company _____ Phone Number _____

Insurance Company PO Box _____ City _____ State _____ Zip_____

Employer _____ Group Number _____

Dental History (if information is known)

Name of previous dentist _____ Phone number _____

When was your last exam and cleaning? _____ X-Rays? _____

Do you have any questions about dentistry and oral health that you would like to discuss?

_____

_____

_____

Our practice is built on providing care to satisfied patients. As said before, our intent is to earn the trust you have shown by choosing us as your dental providers. We hope to serve you in a manner that will bring you to enthusiastically recommend us to your family, friends, and others in your community. Thank you!

JAYNA SEKIJIMA, DDS

SHORELINE DENTIST

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of the Statement of Privacy Practices for the dental office of Jayna Sekijima, DDS, containing a more complete description of the uses and disclosures of my protected health information (PHI) under the Health Insurance Portability & Accountability Act of 1996 **(HIPAA).** I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have the right to review and receive a copy of such Statement of Privacy Practices. I understand that my dental provider has the right to change the Statement of Privacy Practices and that I may contact this office to obtain a current copy of the Statement of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

ADDITIONAL DISCLOSURE AUTHORIZATION

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information (PHI) to the person(s) identified below.

- Spouse ☐ YES ☐ NO
- Any Member of my immediate family: (i.e. Spouse, Children, Children's Spouses) ☐ YES ☐ NO
- Any Member of my extended family: (i.e. Parents, Grandchildren) ☐ YES ☐ NO
- Other (indicate here): _____ ☐ YES ☐ NO

Patient Name (please print): _____

Patient Signature (if 18+ years of age): _____ **Date:** _____

Patient's Personal Representative (please print): _____

Personal Representative Signature: _____ **Phone:** _____

FOR OFFICE USE ONLY:

We were unable to obtain the patient's written acknowledgement of our Statement of Privacy Practices due to the following reason:

☐ The patient refused to sign ☐ Communication barriers ☐ Emergency situation ☐ Other _____

JAYNA SEKIJIMA, DDS

SHORELINE DENTIST

FINANCIAL AND APPOINTMENT POLICIES

Welcome, we are happy to have you as our patient and consider it our privilege to provide for your oral health needs. As we establish your account, please take the time to read our financial and appointment policies.

Our commitment to you: Before treatment is performed, we will discuss the treatment options available, as well as treatment cost estimates.

All payments are due at the day of service. We accept payments in the form of **cash, checks, Visa, MasterCard, HSA, FSA** and financing through **Care Credit.**

Insurance: As a courtesy to our patients, we are happy to submit claims to your insurance company. Recognizing that your dental coverage is a relationship between you and your insurance company, we will do everything we can to accurately estimate any benefits allowable on your plan but cannot guarantee what your insurance will ultimately pay on your behalf. We ask that estimated fees not covered by your insurance be paid at the time of service. For major treatment, we will ask for about 50% or $400 down depending on your insurance benefits.

Cash Patients: We offer a courtesy discount for patients who do not have insurance. These include either a 5% courtesy discount for cash / check payments, a 3% discount for payments made with a credit card, or a 5% discount for patients 65 or older.

Appointments are reserved exclusively for you. There is a **$75.00 charge** for any broken appointments. Broken appointments are considered those that are missed (no-show) or cancelled with less than **two business days advance notice**.

By signing below, I acknowledge that I have received, understand, and agree to the financial and appointment expectations for services rendered at Jayna Sekijima, D.D.S.

Patient Name (please print): _____ **Date:** _____

Consenter's Signature: _____ **Relationship to patient:** _____

JAYNA SEKIJIMA, DDS

SHORELINE DENTIST

HEALTHCARE RECORDS RELEASE AUTHORIZATION FORM

Patient Name: _____ Date of Birth: _____

Previous Dentist: _____

Address: _____

Email: _____ Phone: _____

I hereby request and authorize the above named to send complete medical and/or dental records to:

JAYNA SEKIJIMA, DDS

701 N 182nd Street, Suite 102
Shoreline, WA 98133

Phone: (206) 542-7600 **Fax:** (206) 542-7727 **Email:** info@shoreline-dentist.com

Signature: _____ Date: _____

Relationship to patient (if signed by authorized representative): _____

** BELOW TO BE COMPLETED AND RETURNED BY PREVIOUS DENTIST **

Date of last visit to your office: _____

Date of last Full Mouth X-rays: _____

Date of last Pano:_____

Date of last series of Bitewing/Periapical X-rays: _____

Scaling and root planing dates: _____

Date of last Prophy D1110 or Perio Maintenance D4910 (please circle which): _____

**Please send most recent FMX, Pano, BWs/PAs, perio chart,
and records of implant placement and/or restoration (if applicable).**

Thank you!