Lake City Smiles

PATIENT INFORMATION

12733 Lake City Way NE, #201 Seattle, WA 98125
Ph: (206) 365-2244 Fax: (206) 365-2256

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Name:_____
Last First MI

Date of birth:_____SEX:____Marital Status:_____Soc. Sec #_____

Home Phone:(____)_____Cell Phone:(____)_____

Home Address:_____

City:_____State:_____ZIP:_____

Email:_____

Name of your medical doctor:_____Phone Number_____

How did you hear about us:_____

Emergency Contact Number:(____)_____Name:_____

INSURANCE AND EMPLOYER INFORMATION

EMPLOYEE OR INSURED PERSON:_____

SS#_____Date Of Birth:_____

Insurance Company:_____

Insurance phone number:(____)_____Group #:_____

Employer Company:_____Phone:_____

Address:_____

City:_____State:_____ZIP:_____

AUTHORIZATION

I hereby authorize Seng Yea D.D.S. to be attending dentist and to administer to me any examination, treatment and medication he deems therapeutic to my presenting complaints. I hereby authorize Seng Yea D.D.S. to furnish information to insurance carriers concerning this illness, and I hereby irrevocably assign to the doctor all payments for my dental services rendered.

Signature: x_____**Date:**_____

Update_____/_____/_____

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PATIENT MEDICAL HISTORY

Name of patient

Physician | Office Phone | Date of last exam

	Y	N
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, what medicaito _archi		
4. Have you ever taken Phen-Fen/Redux?		
5. Do you use tobacco?		
6. Do you use controlled substances?		
7. Are you wearing contact lenses?		
8. Do you have or have you had any of the following?		

BP=

	Y	N
High Blood Pressure		
Low Blood Pressure		
Heart Attack		
Rheumatic Fever		
Chest Pains		
Fainting / Seizures		
Asthma		
Epilepsy / Convulsions		
Leukemia		
Diabetes		
Kidney Diseases		
AIDS or HIV Infection		
Thyroid Problem		

	Y	N
Heart Disease		
Cardiac Pacemaker		
Heart Murmur		
Angina		
Stroke		
Anemia		
Emphysema		
Cancer		
Arthritis		
Joint Replacement or Implant		
Hepatitis / Jaundice		
Sexually Transmitted Disease		
Stomach Troubles / Ulcers		

	Y	N
9. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (eg. Novocaine)		
Penicillin or any other Antibiotics		
Sulfa Drugs		
Barbiturates		
Sedatives		
Iodine		
Aspirin		
Any Metals (eg. Nickel, mercury etc)		
Latex Rubber		
Other (please list)		
Hay Fever / Allergies		
Tuberculosis		
Radiation Therapy		
Glaucoma		
Liver Disease		
Respiratory Problems		
Mitral Valve Prolapse		
Eating Disorders		
10. Women Only:		
a) Are you pregnant or may be pregnant?		
b) Are you nursing?		
c) Are you taking oral contraceptives?		

PATIENT DENTAL HISTORY

	Y	N
1. Do your gums bleed while brushing or flossing?		
2. Are your teeth sensitive to hot or cold liquid/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 your 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		

	Y	N
8. Do you have frequent headaches?		
9. Do you clench or grind your teeth?		
10. Do you bite your lips or cheeks?		
11. Have you ever had any difficult extractions in the past?		
12. Have you had orthodontic treatment?		
13. Do you wear dentures or partials?		
If yes, date of placement		
14. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?		
15. 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 or staff 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 a third party payers 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 also understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Date _____

Signature of patient (or parent if minor)

Doctors comments _____ Update: _____

Doctors signature _____ Date

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Written Financial Policy

Thank you for choosing Lake City Smiles. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Check, Visa, Mastercard, Cash

  We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with check, credit card or cash prior to completion of care for treatment plans of $500 or more.

- NO INTEREST[1] Payment Plans[2] from CareCredit
  - Allow you to pay over time with NO INTEREST[1]
  - Convenient, low monthly payment plans[2] also available
  - No annual fees or pre-payment penalties

Please note:

Lake City Smiles requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For plans requiring multiple appointments, alternative payment arrangements may be provided.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[3]

A fee of $75 is charged for patients who miss or cancel more than 2 times in a calendar year without 48-hour notice.

Lake City Smiles charges $40 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

[2]Subject to credit approval

[3]However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

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Acknowledgment of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Seng Yea, DDS, PS. 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.

Seng Yea, DDS, PS 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	Yes	No
SPOUSE ONLY	Yes	No
OTHER (PLEASE SPECIFY)	Yes	No

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledgement Not Obtained	
Provided prior to treatment?	☐ **YES** ☐ **NO**
Date Provided:	
Reason for Denial:	☐ Needed more time to review statement of privacy practices ☐ Wanted to consult with another person before signing ☐ Unable to sign ☐ Reason not given ☐ Other (explain):