

19th Avenue Dental

Dental History

Why have you come to the dentist today? _____

- Do you currently have pain or swelling?..... Yes No
- Do you desire complete dental care?..... Yes No
- Are your teeth sensitive to heat, cold, or sweets?..... Yes No
- Do you have difficulty chewing food?..... Yes No
- Do you grind or clench your teeth?..... Yes No
- Do you ever have pain in your jaw joint or muscles?..... Yes No
- Do you have clicking or popping in your jaw joint?..... Yes No
- Do your gums ever bleed?..... Yes No
- Have you ever had periodontal disease?..... Yes No
- Are you worried about receiving dental treatment?..... Yes No
- Would you prefer using laughing gas (nitrous oxide)?..... Yes No
- Do you gag easily?..... Yes No
- Your current dental health is?..... Good Fair Poor

Previous/Present Dentist: Name _____ City _____

Date of Last Visit: _____ When was your last cleaning? _____

Are you happy with the color of your teeth?..... Yes No

Are you happy with the way your smile looks?..... Yes No

If not, what would you change? _____

Have you ever noticed slow healing sores in or around your mouth?..... Yes No

Have you lost any teeth?..... Yes No

Is it important to you to retain your natural teeth?..... Yes No

How many times a day do you brush? _____

How many times a day do you floss? _____

Is there anything else we should know? _____

Consent:

The undersigned hereby authorizes Dr. Yamaguchi to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Yamaguchi to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Yamaguchi to perform any and all forms of treatment, medication, and further authorize and consent that Dr. Yamaguchi choose and employ such assistance as he deems fit. I also understand the use of anesthetic agent embodies a certain risk. I understand that responsibility for payment for dental services provided at this office for myself or my dependents is mine, due and payable at time services are rendered. I further understand that a 1.5 finance charge (18% annually) will be added to any balance over 30 days.

Today's Date _____ Patients' Signature _____

If patient is a minor, guardian or parent must sign

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We look forward to providing you with complete and personal dental care. We would like to gather information about your goals and current dental health to diagnose your dental needs. Together we would like to review your dental information and develop a treatment plan that fits those needs. Out of respect for your time, our time and our many other patients, please review our policies listed below.

Cancellations and No Shows

As a courtesy to our office, please make any changes or cancellations **48 hours** prior to your scheduled appointment. A cancellation with less than 24 hours notice or failure to show for an appointment may result in a charge to your account at a minimum of \$40.00, and is at the Office Manager and Dr. Yamaguchi's discretion. In some cases the cancellation fee must be paid before we can reschedule an appointment. Frequent short notice cancellations or failures may result in patient dismissal.

Timeliness

We value your time and don't want to keep you waiting. Occasionally, we are delayed by an unexpected procedure with another patient, but please be assured that the quality of your treatment will not suffer. If you arrive late, your treatment will end at the scheduled time in order to not keep the next patient waiting. If you arrive too late, it may be necessary to reschedule your appointment.

Emergencies

For patients of record we do our best to respond promptly to your needs. However, out of respect to our previously scheduled patients, we appreciate your flexibility as we work you into the best opening in our schedule.

Insurance

As a courtesy we bill your insurance company, if we are provided the necessary information. Your insurance is a contract between you, your employer and the insurance company. We are not a party in that contract.

Financial Policy

If you do not have insurance, we require full payment for treatment at each visit. For those with insurance, we will estimate approximate out of pocket portion which is due at the time of treatment. Once the insurance has paid there may be a residual balance owing, which is the patient's responsibility.

We accept cash, check, Visa, or MasterCard. For those requiring a payment plan, we work with a finance company called Dental Fee Plan that may be able to assist you. It is important to communicate any financial problems as soon as possible. Any account balance over 90days is subject to an interest charge of 1.5% per month (18% annually), minimum charge \$1.00. Please notify the receptionist of any changes in phone, address, or insurance information, as well as any changes in your health or medications.

.....
I acknowledge that I have read and understand the policies stated above. I, the undersigned, hereby agree that in the event of default of any amount due, and if the account is placed in the hands of an agency or attorney for collection or legal action, to pay the costs including agency, attorney fees and court costs incurred.

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Medical History

Do you have a personal physician?.....Yes No

Physician's

Name _____

Phone#(_____) _____ Date of last visit _____

Your current health is.....Good Fair Poor

Are you currently receiving treatment by a physician?.....Yes No

Please explain _____

Do you smoke or use tobacco products?.....Yes No

Are you taking any prescriptions/over-the-counter drugs?.....Yes No

If yes, please list each one _____

For Women: Are you currently taking birth control pills?.....Yes No

Are you pregnant?.....Yes No

Week# _____ Are you nursing?.....Yes No

Do you have or ever had any of the following?

- | | | | | | |
|---|---|-----------------------------------|---|---|------------------------------|
| Y | N | Anemia/Radiation Treatment | Y | N | Heart Surgery/Pacemaker |
| Y | N | Artificial Bone/Joints | Y | N | Hemophilia/Abnormal Bleeding |
| Y | N | Artificial Valves | Y | N | Hepatitis |
| Y | N | Asthma | Y | N | High/Low Blood Pressure |
| Y | N | Arthritis | Y | N | HIV+/AIDS |
| Y | N | Blood Transfusion | Y | N | Hospitalized for any reason |
| Y | N | Cancer/Chemotherapy | Y | N | Kidney Problems |
| Y | N | Congenital Heat Defect | Y | N | Mitral Valve Prolapse |
| Y | N | Diabetes | Y | N | Psychiatric Condition |
| Y | N | Difficulty Breathing/Emphysema | Y | N | Rheumatic/Scarlet Fever |
| Y | N | Drug/Alcohol Abuse | Y | N | Severe/Frequent Headaches |
| Y | N | Epilepsy/Seizures/Fainting Spells | Y | N | Shingles |
| Y | N | Fever Blisters/Herpes | Y | N | Sinus Problems |
| Y | N | Glaucoma | Y | N | Tuberculosis(TB) |
| Y | N | Heart Attack/Stroke | Y | N | Ulcers/Colitis |
| Y | N | Heart Murmur | Y | N | Venereal Disease |

Please list any serious condition(s) you have either had or have not listed above: _____

Are you allergic to any of the following?

- | | | | | | |
|---|---|--------------------|---|---|--------------|
| Y | N | Aspirin | Y | N | Latex |
| Y | N | Codeine | Y | N | Penicillin |
| Y | N | Dental Anesthetics | Y | N | Sedatives |
| Y | N | Erythromycin | Y | N | Sulfa Drugs |
| Y | N | Jewelry/Metals | Y | N | Tetracycline |

Please list any drugs that you are allergic to not listed above: _____

Today's Date _____ Patient's Signature _____

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Today's Date _____ Provider Signature _____

19th Avenue Dental

Shuichi Yamaguchi, D.D.S., P.S.
10217 19th Avenue SE, Ste. 203
Everett, WA 98208
(425) 385-8130 • (425) 385-2658 Fax

Patient's Name _____ Birth Date _____ Age _____
S.S.# _____ Gender _____ Married _____ Single _____
Address _____ Mailing (if different) _____
City _____ State _____ Zip _____
Home Phone _____ Cell or Work Phone _____
Student? What School? _____
Email Address _____
Responsible Party if patient is a minor _____
Relationship to patient _____ Employer _____
Work Phone _____ Emergency Contact & Phone _____

Insurance 1st Coverage

Insurance 2nd Coverage

Employee Name _____	_____
Employer _____	_____
Insurance Co. Name _____	_____
Insurance Phone _____	_____
Policy or ID# _____	_____
Union Local or Group # _____	_____
S.S.# _____	_____
Birth Date _____	_____
Relationship to Patient _____	_____

Whom may we thank for referring you? _____

Release of Benefits and Information: I authorize my insurance benefits to be paid directly to the doctor of this facility. I understand that I am responsible for any balance due and outstanding. I authorize the doctor or insurance company to release any information required for this and subsequent claims on my behalf. If the office incurs expenses in trying to collect from me, such as filing a lawsuit, I agree to pay any responsible collection costs, including, but not limited to attorney's fees. I am obligated to pay said dental center in accordance with its credit terms and policies.

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