JADE K. KIM DDS PS
2401 North 45th Street, Seattle WA 98103 206.632.1214

Patient Registration

Personal Information

Legal Name _____ D.O.B: _____
Preferred Name_____ Preferred Gender Pronoun: **HE/SHE/THEY**
Address _____City_____ State_____ Zip_____
Email Address _____ SSN#_____
Home: _____ Cell: _____Current Employer_____

Emergency Contact_____Phone #_____

How did you hear about us? _____

Dental History

Previous Dentist _____ Phone #_____
Last Dental Visit _____ Last Dental X-Rays _____

PLEASE TAKE NOTICE, IF WE DO NOT HAVE A CURRENT, CLEAR, FULL SET OF XRAYS ON FILE BEFORE YOUR APPOINTMENT, WE WILL BE REQUIRED TO TAKE ONE, WITH *MINIMAL* EXCEPTIONS.

OUR OFFICE TAKES A PANORAMIC EVERY 3-5 YEARS. THIS IS A 2D IMAGE BILLED TO INSURANCE. A 3D IMAGE IS AVAILABLE UPON REQUEST FOR A $350 CONVERSION CHARGE. X_____ (initial)

What is the most important thing to you about your visit today?	**How often do you brush your teeth per day?**
	How often do you floss?
	What type of toothbrush do you use?

Do your gums bleed when you brush or floss?	**Yes / No**	Do you clench or grind your teeth?	**Yes / No**
Are your teeth sensitive to hot, cold, sweets or Pressure?	**Yes / No**	Are you currently experiencing any dental pain or discomfort?	**Yes / No**
Do you have sleep apnea?	**Yes / No**	Do you have earaches or neck pain?	**Yes / No**
Are you being treated for sleep apnea?	**Yes / No**	Do you have clicking, popping or discomfort in the jaw?	**Yes / No**
Do you have dry mouth?	**Yes / No**	Are you interested in teeth whitening?	**Yes / No**
Do you wear dentures or partials?	**Yes / No**	Would you like to change your smile?	**Yes / No**
Have you been diagnosed with periodontal Disease (Gum Disease)? **If Yes**, have you ever had scaling & root planing (deep cleaning)?	**Yes / No**	Have you had orthodontic (braces) treatment? **Yes / No** **If No**, are you interested?	
Have you had any problems associated with previous dental procedures/treatment? (E.g. dental anesthesia) **If yes**, please explain.			**Yes/ No**
Do you have any dental phobias? Would you like Nitrous or Oral Sedation for your appointments? (Associated Fees)			**Yes / No**

MEDICAL HISTORY

PATIENT NAME _____ **Birth Date** _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes / No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	Yes / No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes / No	If yes, please explain: _____
Are you taking any medications, pills, or drugs? (e.g. blood thinners like Coumadin or Warfarin)	Yes / No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	Yes / No	If yes, please explain: _____
Have you ever taken Fosamax, Boniva, Prolia or any medications containing bisphosphates for osteoporosis or bone cancer?	Yes / No	If yes, please explain: _____
Do you use tobacco?	Yes / No	
Are you on a special diet?	Yes / No	If yes, please explain: _____
Do you use controlled substances?	Yes / No	If yes, please explain: _____
Do you need to pre-medicate?	Yes / No	If yes, please explain: _____

Women: Are you Pregnant/Trying to get pregnant? Yes / No **Taking oral contraceptives?** Yes / No **Nursing?** Yes / No

Are you allergic to any of the following?

- ○ Aspirin
- ○ Penicillin
- ○ Codeine
- ○ Acrylic
- ○ Metal
- ○ Latex
- ○ Local Anesthetics
- ○ Sulfa Drugs

Other? _____ **If yes, please explain:**

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes / No	Cortisone Medicine	Yes / No	Hemophilia	Yes / No	Radiation Treatments	Yes / No
Alzheimer's Disease	Yes / No	Diabetes	Yes / No	Hepatitis A	Yes / No	Recent Weight Loss	Yes / No
Anaphylaxis	Yes / No	Drug Addiction	Yes / No	Hepatitis B or C	Yes / No	Renal Dialysis	Yes / No
Anemia	Yes / No	Easily Winded	Yes / No	Herpes	Yes / No	Rheumatic Fever	Yes / No
Angina	Yes / No	Emphysema	Yes / No	High Blood Pressure	Yes / No	Rheumatism	Yes / No
Arthritis/Gout	Yes / No	Epilepsy or Seizures	Yes / No	High Cholesterol	Yes / No	Scarlet Fever	Yes / No
Artificial Heart Valve	Yes / No	Excessive Bleeding	Yes / No	Hives or Rash	Yes / No	Shingles	Yes / No
Artificial Joint	Yes / No	Excessive Thirst	Yes / No	Hypoglycemia	Yes / No	Sickle Cell Disease	Yes / No
Asthma	Yes / No	Fainting Spells/Dizziness	Yes / No	Irregular Heartbeat	Yes / No	Sinus Trouble	Yes / No
Blood Disease	Yes / No	Frequent Cough	Yes / No	Kidney Problems	Yes / No	Spina Bifida	Yes / No
Blood Transfusion	Yes / No	Frequent Diarrhea	Yes / No	Leukemia	Yes / No	Stomach/Intestinal Disease	Yes / No
Breathing Problem	Yes / No	Frequent Headaches	Yes / No	Liver Disease	Yes / No	Stroke	Yes / No
Bruise Easily	Yes / No	Genital Herpes	Yes / No	Low Blood Pressure	Yes / No	Swelling of Limbs	Yes / No
Cancer	Yes / No	Glaucoma	Yes / No	Lung Disease	Yes / No	Thyroid Disease	Yes / No
Chemotherapy	Yes / No	Hay Fever	Yes / No	Mitral Valve Prolapse	Yes / No	Tonsillitis	Yes / No
Chest Pains	Yes / No	Heart Attack/Failure	Yes / No	Osteoporosis	Yes / No	Tuberculosis	Yes / No
Cold Sores/Fever Blisters	Yes / No	Heart Murmur	Yes / No	Pain in Jaw Joints	Yes / No	Tumors or Growths	Yes / No
Congenital Heart Disorder	Yes / No	Heart Pace Maker	Yes / No	Parathyroid Disease	Yes / No	Ulcers	Yes / No
Convulsions	Yes / No	Heart Trouble/Disease	Yes / No	Psychiatric Care	Yes / No	Venereal Disease	Yes / No
						Yellow Jaundice	Yes / No

Have you ever had any serious illness not listed above? Yes / No **If yes, please explain**:

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Jade K. Kim DDS PS

HEALTH INFORMATION PRIVACY POLICIES & PROCEDURES

I understand that as part of my healthcare, the office of **Dr. Jade Kim DDS PS** originates and maintains health records describing my health history, symptoms, examination, test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as a:

- Basis for planning care and treatment
- Means of communication with healthcare professionals who contribute to my care
- Source of information for applying dental information to my bill
- Verification medium to ensure services billed were provided, by third-party payer
- Tool to assess and review routine healthcare operation

I understand I have the right to:

- **Object** to the use of my health information for directory purposes
- **Revoke** this consent in writing
- **Request** restrictions to the disclosure of healthcare information

Notice: *The following email addresses, info@jadekimdds.com & frontdesk@jadekimdds.com, are not secured by encryption. Please refrain from including any personal information. If you are concerned about sending information through an unsecure email, please call our office.*

I request the following restrictions to the use or disclosure of my healthcare information:

Patient:

_____

Print Name

_____ _____

Signature **Date**

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Cancellation/No Show Policy

We make every effort to schedule your appointment at a convenient time for you. It is very important that you keep your appointment as scheduled as we are committed to providing the best care to improve your oral health. Due to this, we request 48 business hours' notice if changes need to be made to your appointment. Our policy concerning cancelled or failed appointments is as follows:

1. **Cancellation/ No Show**

   If an appointment is not cancelled with at least 48 business hours' notice or you do not show up for your appointment, you will be charged a $50 fee.

2. **Late to Scheduled Appointments**

   We respect the time of our patients and if you arrive **15 minutes** past your scheduled time, we will have to reschedule the appointment. This will be considered a late cancellation and you will be charged a $50 fee.

3. **Cancellation/No Show Policy for Large Appointments**

   Due to the large block of time reserved for certain procedures (e.g. Crown, Implant, Deep Cleanings, etc.) cancellations with less than **48 business hours'** notice will be charged a $75 fee.

These fees will not be covered by your insurance and will be your responsibility. No future appointments will be scheduled or records transferred without payment of this fee.

If you have any questions regarding this policy, please let our staff know and we will be glad to answer any questions you have.

My signature below indicates that I have read and accepted the above statements.

PATIENT OR RESPONSIBLE PARTY _____ **DATE**_____

Jade K. Kim DDS PS

Payment Policy Acknowledgement

Thank you for choosing our office for your dental care. Our primary goal is to provide our patients the best possible dental care, at an affordable cost. In an effort to provide high quality care to all of our patients, payments for services are due in full at the time treatments/services are completed.

For the convenience of our patients we offer the following methods of payment

A. Payment in full by cash, check or bank card
B. For insurance patients, we are a preferred provider of most major Dental Insurances
C. Major Services: Partials, Dentures, Appliances, Crowns, Bridges- payment in full with courtesy payment of ½ at initial appointment and ½ upon completion.
D. Basic/Preventative Services: Fillings, Periodontal Treatment, Extractions, etc. – payment in full after service
E. We also accept, a 3rd party dental financing called **Care Credit**, that allows you to start your treatment now, and make payments over time without incurring interest charges for a contracted period.

Please be aware that any parent bringing a child to our office is legally responsible for payment of all services rendered
Account balances that have not received payment in over 60 days will incur a 7% INTEREST PER MONTH
Delinquent accounts after 90 days will be sent to collections with added service fees

It is important that you realize…

1. Your dental benefit program is a contract between you, your employer, and the insurance company. We are not a party to that contract. This office files your insurance electronically as a courtesy to you.
2. Not all dental services are covered benefit in all contracts
3. You (not the insurance company) are responsible to us for all of the fees for services rendered to you
4. For patients who have insurance, an **ESTIMATE** of treatment cost will be provided depending on EOB (Estimation of Benefits), and any co-payment is expected to be paid in full at the time services are rendered.

We will gladly discuss your proposed dental treatment and answer any questions you might have as to the involvement of your dental benefit program in receiving care.

CONSENT TO TREATMENT AT THIS OFFICE

There are some risks in all dental procedures. Specific risks include but are not limited to infections, swelling, pain, discoloration, and partial or complete, permanent or transient numbness or paresthesia of areas of the oral cavity. Sometimes there are complications that cannot be foreseen. If we are not able to resolve your chief complaint, we will assist you in finding a specialist that can accommodate your needs.

Alternative methods of treatment and the consequences of no treatment will be explained. The procedures involved in dental treatment include the use of anesthetics, sedatives and other medications. Changes in any treatment plan will be discussed with you for your approval.

You may ask questions regarding any proposed procedure and the risk involved in any future treatments that are proposed to you.

My signature below indicates that I have read and accepted the above statements.

PATIENT OR RESPONSIBLE PARTY _____**DATE**_____

PRINTED NAME _____