Sue Lim DDS & Steven Machida DDS
Lynnwood Family Dentistry
19514 64th Ave W Suite A
Lynnwood, WA 98036
P: 425-771-0165 F: 425-670-1185
www.lynnwoodfamilydentistry.com

Welcome to our office! We appreciate the confidence you place in us to provide dental services. To assist us in serving you, please complete the following forms. If you have any questions, don't hesitate to ask.

Date: ______________________

Referral Information

How did you first hear about our office? Yellow Pages Internet/Website Referred Drive-By
Insurance Listing Other ____

If referred, whom may we thank for referring you? ______________________________________

Patient Information

Full Name: ____ Nick Name: ____________________
Home Address: ____ Apt #: ____________________
City, State, Zip: ____ Cell/Home #: ________________
Date of Birth: ______________________ Sex M F Single Married Div. Widowed
Occupation: ____ Work Tel #: ____________________
Employer or Name of Business: ______________________________ Email: ______________________

Responsible Party

(Parent/Guardian or Person Responsible for Account)

Name: ____
Address (if different from above): ___________________________________ Apt #: ______________
City, State, Zip: ____ Cell/Home #: ______________
Date of Birth: ______________________ Driver's License #: ______________________________
Occupation: ____ Work Tel #: ____________________
Employer or Name of Business: ______________________________ Email: ______________________

INSURANCE INFORMATION

Primary Carrier Information

Name of Insured: ______________________________
SSN of Insured: ______________________________
Patient's relationship to the insured: (check)
Self Spouse Dependent

Insurance Company
Name: ______________________________
Phone #: ______________________________
Group #: ______________________________
Policy #: ______________________________

Secondary Carrier Information

Name of Insured: ______________________________
SSN of Insured: ______________________________
Patient's relationship to the insure: (check)
Self Spouse Dependent

Insurance Company
Name: ______________________________
Phone #: ______________________________
Group #: ______________________________
Policy #: ______________________________

Assignment & Release

By my typed name or signature below, I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due and authorize the dentist to release any information required for this claim. I authorize that my records can be used by the doctor if he so determines.

In consideration of the service rendered to me by this dental office, I am obligated to pay said in accordance with its credit terms and policy. Also, I consent to the taking of photographs and x-rays before, during and after treatment.

By my typed name or signature below, I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

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 our office.

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 typed name or signature below, I acknowledge receipt of the Notice of Privacy Practices.

____	______________________________
Patient or legally authorized individual signature	Date
____	______________________________
Printed Name	Relationship to Patient

Accident Information

Date of Accident/Injury: ______________________ Place and time of Accident/Injury______________

Name of Responsible Insurance Company:____

Address, City, State, Zip (Insurance): ____

Telephone #: ______________________________ Policy holder name: _______________________

Claim #:__________________________________ Attorney name: ___________________________

Address, City, State, Zip (Attorney): ________________________________ Telephone #: ____________

Other pertinent data: ____

____

____

LYNNWOOD FAMILY DENTISTRY

Patient Name: ______________________________ Today's Date: ______________

Patient's Date of Birth: ______________________________ Age: ________

In case of emergency, notify: ______________________________ Relationship to you: ____________
(Name & Phone #)

Confidential Medical Health History

Physician: ______________________________ Date of last physical Exam: ____________
(Name & Phone #)

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

- ○ Heart Problems
- ○ Heart Murmur
- ○ Artificial Heart Valve
- ○ High Blood Pressure
- ○ Rheumatic/Scarlet fever
- ○ Stroke
- ○ Prolonged Bleeding
- ○ Pacemaker
- ○ Lung Problems
- ○ Tuberculosis
- ○ Sinus Problems
- ○ Allergies
- ○ Stomach Problems
- ○ Intestinal Problems
- ○ Prosthetic Joint(s)
- ○ Diabetes
- ○ Hepatitis
- ○ Thyroid Problems
- ○ Kidney Problems
- ○ Bladder Problems
- ○ Seizures/Epilepsy
- ○ Cancer / Tumor
- ○ Counseling for stress / Anxiety / depression
- ○ HIV Positive / AIDS
- ○ Herpes
- ○ Sexually Trans. Disease
- ○ Alcoholism/Drug Abuse
- ○ Glaucoma
- ○ Other

List any MEDICATIONS you are currently taking: ______________________________

____

Are you ALLERGIC to any medication and/or latex gloves? ______________________________

Do you have or have you had any illness or problem not listed above that we should know about? ______________

____

____

Women: Are you pregnant? ______________ If yes, which trimester? ______________

Are you taking contraceptives or hormones? ______________________________

Dental Health History

Previous Dentist: ______________________________ Date of last dental visit: ____________
(Name & Phone #)

Do you have or do you use any of the following?

- ○ Teeth sensitive to cold, heat, sweets or pressure
- ○ Bleeding gums
- ○ Food impaction
- ○ Clenching or grinding
- ○ Swelling or lumps of mouth
- ○ Bad breath/Unpleasant taste
- ○ Oral habits, i.e. fingernail biting, cheek biting, etc
- ○ Unfavorable dental experience
- ○ Complications from extraction
- ○ Orthodontic treatment
- ○ Frequent blisters on lips or mouth
- ○ Chewing Tobacco
- ○ Smoking cigarette/cigar/pipe
- ○ Periodontal treatment
- ○ Mouth breathing
- ○ Problems with TMJ

How often do you brush your teeth? ______________________ Floss? ______________________

By my typed name or signature below, I hereby certify that the above information is true and correct to the best of my knowledge.

Signed: ______________________________ Date: ______________

LYNNWOOD FAMILY DENTISTRY
FINANCIAL POLICY AND AGREEMENT

Welcome to Lynnwood Family Dentistry. We hope your visits will be pleasant and relaxing. We have found that a clear understanding of our financial policies relieve some of the anxiety associated with going to the dentist. For your convenience we offer several different payment plans as explained below.

CASH OR CHECK

For patients who have no insurance, we ask that you pay for your dental services at the end of each appointment. This entitles you to a 3% cash discount. If you are a senior citizen (65 years+) please ask about our special courtesy just for you.

VISA OR MASTER CARD

We are happy to accept these credit cards for payment at the end of each appointment. However, none of our discounts apply when using credit cards. There will be a 3% processing fee added to all monthly payments on a credit card, along with a $10 administration fee per payment.

DENTAL INSURANCE

We honor most dental insurance plans and will assist in processing all claims that are assigned. At the end of each visit, please pay **your portion** for any treatment rendered. We do provide estimates for services, but they are only estimates. The final balance and settling of your account won't be known until your insurance claim is paid.

Note: You, not your insurance company, are financially responsible for the entire dental bill, including any balance due after your insurance company has paid its portion.

WE WOULD ALSO LIKE YOU TO KNOW

For all procedures requiring laboratory work, payment must be made at the end of each appointment to cover laboratory expenses.
Our office requires a minimum of **48 business hours notice** (preferably, longer if possible) if you cannot make your appointment. Please remember **we are closed on Friday** and it does not count as our business hours. A **$60.00** per hour charge will be assessed after the first two appointment cancellations without proper notification.

We reserve the right to run random credit reports on accounts.

Monthly payment plans are available on large treatment plans. Financial arrangement must be made prior to your first treatment appointment. Interest will be added to unpaid balance over 30 days at the rate of 1.5% per month (18% per year).

By my typed name or signature below, I acknowledge that I am financially responsible for all fees whether or not paid by insurance. In the event of default of any amount due, and if the account is submitted to collection agency, I agree to pay all collection costs including reasonable attorney fees.

Signature: ____ Date: ____________________

Medical Record Release Authorization

Patient Name: ____ Date of Birth: _________

Address: ____

City: _______________________________ State: ___________ Zip Code: ___________

I request and authorize ____
to release my medical record information to:

Lynnwood Family Dentistry
19514 64th Ave W Suite A
Lynnwood, WA 98036
425.771.0165
425.670.1185 (Fax)
Email: reception@lynnwoodfamilydentistry.com

By my typed name or signature below, I understand that my consent is required to release any and complete health care information concerning the medical and dental findings and treatment. I agree to have any/or all of my health care record released to the appropriate named above. I release Dr. Sue K Lim and Dr. Steven M Machida from any laws related to disclosure of confidential or privileged information.

____ ____________________
Signature of Patient or Patient's Authorized Representative Date Signed

____
Relationship if Signed by Anyone Other Than Patient