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: _____ Nickname: _____

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: _____ Date of Birth: _____

Address (if different from above): _____ City, State, Zip: _____

Cell/Home #: _____ Work Tel #: _____ Email: _____

Occupation: _____ Employer or Name of Business: _____

INSURANCE INFORMATION

Primary Carrier Information	Secondary Carrier Information
Name of Main Holder: _____	Name of Main Holder: _____
SSN of Main Holder: _____	SSN of Main Holder: _____
Member/Alternate ID #: _____	Member/Alternate ID #: _____
Patient's relationship to the insured: (check)	Patient's relationship to the insure: (check)
Self ☐ Spouse ☐ Dependent ☐	Self ☐ Spouse ☐ Dependent ☐
Insurance Company	Insurance Company
Name: _____	Name: _____
Phone #: _____	Phone #: _____
Group #: _____	Group #: _____
Policy #: _____	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 or she 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 understand 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. Per Washington State law, your records will be accessible for six years from the date of last treatment, after which we are no longer required to retain your records. Unless otherwise specified, you consent to receiving communications regarding your protected health information using the contact information you provide (i.e. SMS text, email, etc.) or alternative methods of contact that you designate.

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. You may request to see a copy of our Notice of Privacy Practices at any time.

By my typed name or signature below, I certify that I understand the Notice of Privacy Practices, and that I may request to see a detailed copy at any time.

_____ _____

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

Medical Form

Patient Name: _____ 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 and 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 relieves 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 3% processing fee added to all monthly payments on a credit card along with a $10 administration fee.

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 (preferably more, if possible) if you cannot make your appointment. Please note that **we are closed on Friday** and do not count it to our business hours. A **$60.00** per hour charge will be assessed for cancellations or missed appointments without proper notification. Although courtesy reminders may be sent, it is your responsibility to manage your own appointment schedule and for any fees incurred due to missed or canceled appointments.

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 with minimum of $10.00 (18% per year).

By my typed name or signature below, I acknowledge that I am financially responsible for all fees whether paid by insurance or not. 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: _____

LYNNWOOD FAMILY DENTISTRY
Sue K. Lim, DDS & Steven M. Machida, DDS
19514 64th Ave W Suite A, Lynnwood, WA 98036 Phone: (425) 771-0165
reception@Lynnwoodfamilydentistry.com

Medical Record Release Authorization

Patient Name: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____

I release _____ from any laws related to disclosure of confidential or
(Name and phone # of previous dentist)
privileged information, and I authorize them 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 Lynnwood Family Dentistry and thereby Dr. Sue K Lim and Dr. Steven M Machida.

_____ _____
Signature of Patient or Patient's Authorized Representative Date Signed

_____
Relationship if Signed by Anyone Other Than Patient