JAYNA SEKIJIMA, DDS

SHORELINE DENTIST

Welcome, and thank you for choosing us as your dental providers. Our intent is to earn the trust you have shown by choosing us as your dental office. Please help us by completing the following confidential form.

Patient Information

Date _____

Last Name _____ First Name _____ M.I. _____

By what name would you like us to call you? _____ Date of Birth _____ / _____ /_____

Preferred pronouns ☐ She/Her/Hers ☐ They/Them/Theirs ☐ He/Him/His ☐ Other: _____

Marital Status ☐ S ☐ M ☐ D ☐ W

Street Address _____ Home Phone _____

City/State/ZIP _____ Cell Phone _____

Email _____ Work Phone _____

Employer _____ Occupation _____

Responsible Party (If different from above)

Name _____ Relationship to Patient _____

Billing Street Address _____ Home Phone _____

Billing City/State/ZIP _____ Cell Phone _____

Email _____ Work Phone _____

Emergency Contact

Name _____ Relationship to the Patient _____

Phone Numbers H _____ C _____ W _____

How did you find out about our office?

_____

JAYNA SEKIJIMA, DDS
SHORELINE DENTIST

MEDICAL HISTORY FORM

Please assist us by completing this form truthfully and to the best of your knowledge so that we can best plan your dental care and avoid any unnecessary personal health risks.

Name: _____ Birth date: _____ Age: _____

Height: _____ Weight: _____ Personal physician: _____ City: _____

What do you consider to be your most important health issues: _____

Is there any activity that your physician says you cannot do? ..... ☐ Yes ☐ No

Have you ever been hospitalized? ..... ☐ Yes ☐ No

Have you been advised by a medical provider that you need to take antibiotics prior to dental treatment? ... ☐ Yes ☐ No

If yes to any of the above, please explain: _____

Do you have or have you ever had any of the following conditions? **Please check Yes or No and circle all that apply.**

Yes ☐ No ☐ **HEART**
Heart surgery
Chest pain / angina / CAD
Heart attack / MI
Congestive heart failure
Congenital heart defect
Heart murmur / artificial valve
Irregular heartbeat
Infective endocarditis
Other: _____

Yes ☐ No ☐ **VASCULAR / BLOOD**
High blood pressure
Low blood pressure
High cholesterol
Atherosclerosis
Blood thinner
Bleeding disorder
Aneurysm
Vascular surgery
Other: _____

Yes ☐ No ☐ **NEUROLOGIC**
Stroke / TIA
Seizures / epilepsy
Parkinson's disease
Neuralgia / Fibromyalgia
Other: _____

Yes ☐ No ☐ **KIDNEY / LIVER**
Acute or chronic renal failure
Dialysis
Hepatitis (A,B,C, autoimmune)
Cirrhosis
Other: _____

Yes ☐ No ☐ **LUNG / AIRWAY**
Asthma
COPD / emphysema
Shortness of breath
Sleep apnea
Other: _____

Yes ☐ No ☐ **ENDOCRINE / HORMONES**
Diabetes
Thyroid disease
Adrenal gland disorder
Gender hormone therapy
Other: _____

Yes ☐ No ☐ **DIGESTIVE TRACT**
Acid reflux / heartburn
Ulcers / GI bleeding
Colitis / Crohn's / IBS
Other: _____

Yes ☐ No ☐ **IMMUNOLOGIC**
Rheumatoid arthritis
Lupus erythematosus
Sjogren's syndrome
Immunosuppressive therapy
Use of prednisone or similar
Other: _____

Yes ☐ No ☐ **MENTAL HEALTH**
Anxiety
Depression
Psychiatric illness
Other: _____

Yes ☐ No ☐ **CANCER**
Type(s): _____
Radiation therapy
Chemotherapy
Surgery

Yes ☐ No ☐ **MUSCULOSKELETAL**
Osteoporosis
Artificial joints
Neck or back pain
Swollen ankles
Other: _____

Yes ☐ No ☐ **HEAD / NECK**
Injury to face, jaws, neck
TMJ disorder
Sinus trouble
Headaches / migraines
Vertigo
Other: _____

Yes ☐ No ☐ **INFECTIOUS DISEASE**
HIV+ / AIDS
Cold sores / fever blisters
Other: _____

Current	Past	Never	**HABITS**
☐	☐	☐	Tobacco
☐	☐	☐	Marijuana
☐	☐	☐	Heavy alcohol / alcoholism
☐	☐	☐	Substance use disorder
☐	☐	☐	*Other:* _____

Provide details of "YES" answers on next page →

Use this space to provide pertinent details of your listed conditions. Please also describe any other conditions or surgeries you have had:

Are you currently taking any medications? ..... ☐ Yes ☐ No

If yes, please list all medications that you are currently taking, including over-the-counter and herbal products:

Drug name:	Dose / Frequency of use:	Reason for taking:

Have you ever taken any anti-resorptive medication to treat osteoporosis or other bone disease? (includes meds below) ..... ☐ Yes ☐ No

Bisphosphonates: alendronate (**Fosamax**), risedronate (**Actonel, Atelvia**), zoledronic acid (**Zometa, Reclast**), ibandronate (**Boniva**), pamidronate (**Aredia**), etidronate (**Didronel**)

RANK ligand inhibitors: denosumab (**Prolia, Xgeva**), bevacizumab (**Avastin, Mvasi**)

Angiogenesis inhibitors: romosozumab (**Evenity**), sorafenib (**Nexavar**), sunitinib (**Sutent**), cabozanitinib (**Cometriq**), everolimus (**Afinitor, Zortress**)

Do you have any known allergies or bad reactions to any medication or other substance..... ☐ Yes ☐ No

If yes, please describe below:

To what:	Type of reaction:	Reaction severity:

FOR WOMEN: Please inform us if you are either pregnant or breastfeeding at the time of any of your dental appointments.

Some medications used in dentistry cross the placenta and breast milk and could affect the baby.

In addition, antibiotic use may reduce the effectiveness of birth control pills, and alternate methods are recommended if the need for antibiotics arises.

I have read and understand the questions on this health history form. To the best of my knowledge, all of the preceding information provided is correct. If I ever have any change in my health, I will inform the office at the next appointment.

_____	_____	_____
Signature of patient, parent, or guardian	Relationship to patient, if applicable	Date

Insurance *(Information is usually listed on insurance card)*

Subscriber's Name _____ Relationship to the Patient _____

Subscriber's Date of Birth ____ / ____ / _____ □ Male □ Female SS# / ID _____

Insurance Company _____ Phone Number _____

Insurance Company PO Box _____ City _____ State _____ Zip_____

Employer _____ Group Number _____

Do you have a secondary insurance? □ Yes □ No If yes, Please complete the following:

Subscriber's Name _____ Relationship to the Patient _____

Subscriber's Date of Birth ____ / ____ / _____ □ Male □ Female SS# / ID _____

Insurance Company _____ Phone Number _____

Insurance Company PO Box _____ City _____ State _____ Zip_____

Employer _____ Group Number _____

Dental History (if information is known)

Name of previous dentist _____ Phone number _____

When was your last exam and cleaning? _____ X-Rays? _____

Do you have any questions about dentistry and oral health that you would like to discuss?

_____

_____

_____

Our practice is built on providing care to satisfied patients. As said before, our intent is to earn the trust you have shown by choosing us as your dental providers. We hope to serve you in a manner that will bring you to enthusiastically recommend us to your family, friends, and others in your community. Thank you!

JAYNA SEKIJIMA, DDS

SHORELINE DENTIST

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of the Statement of Privacy Practices for the dental office of Jayna Sekijima, DDS, containing a more complete description of the uses and disclosures of my protected health information (PHI) under the Health Insurance Portability & Accountability Act of 1996 **(HIPAA).** I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have the right to review and receive a copy of such Statement of Privacy Practices. I understand that my dental provider has the right to change the Statement of Privacy Practices and that I may contact this office to obtain a current copy of the Statement of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

ADDITIONAL DISCLOSURE AUTHORIZATION

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information (PHI) to the person(s) identified below.

- Spouse ☐ YES ☐ NO
- Any Member of my immediate family: (i.e. Spouse, Children, Children's Spouses) ☐ YES ☐ NO
- Any Member of my extended family: (i.e. Parents, Grandchildren) ☐ YES ☐ NO
- Other (indicate here): _____ ☐ YES ☐ NO

Patient Name (please print): _____

Patient Signature (if 18+ years of age): _____ **Date:** _____

Patient's Personal Representative (please print): _____

Personal Representative Signature: _____ **Phone:** _____

FOR OFFICE USE ONLY:

We were unable to obtain the patient's written acknowledgement of our Statement of Privacy Practices due to the following reason:

☐ The patient refused to sign ☐ Communication barriers ☐ Emergency situation ☐ Other _____

JAYNA SEKIJIMA, DDS

SHORELINE DENTIST

FINANCIAL AND APPOINTMENT POLICIES

Welcome, we are happy to have you as our patient and consider it our privilege to provide for your oral health needs. As we establish your account, please take the time to read our financial and appointment policies.

Our commitment to you: Before treatment is performed, we will discuss the treatment options available, as well as treatment cost estimates.

All payments are due at the day of service. We accept payments in the form of **cash, checks, Visa, MasterCard, HSA, FSA** and financing through **Care Credit.**

Insurance: As a courtesy to our patients, we are happy to submit claims to your insurance company. Recognizing that your dental coverage is a relationship between you and your insurance company, we will do everything we can to accurately estimate any benefits allowable on your plan but cannot guarantee what your insurance will ultimately pay on your behalf. We ask that estimated fees not covered by your insurance be paid at the time of service. For major treatment, we will ask for about 50% or $400 down depending on your insurance benefits.

Cash Patients: We offer a courtesy discount for patients who do not have insurance. These include either a 5% courtesy discount for cash / check payments, a 3% discount for payments made with a credit card, or a 5% discount for patients 65 or older.

Appointments are reserved exclusively for you. There is a **$75.00 charge** for any broken appointments. Broken appointments are considered those that are missed (no-show) or cancelled with less than **two business days advance notice**.

By signing below, I acknowledge that I have received, understand, and agree to the financial and appointment expectations for services rendered at Jayna Sekijima, D.D.S.

Patient Name (please print): _____ **Date:** _____

Consenter's Signature: _____ **Relationship to patient:** _____

JAYNA SEKIJIMA, DDS

SHORELINE DENTIST

HEALTHCARE RECORDS RELEASE AUTHORIZATION FORM

Patient Name: _____ Date of Birth: _____

Previous Dentist: _____

Address: _____

Email: _____ Phone: _____

I hereby request and authorize the above named to send complete medical and/or dental records to:

JAYNA SEKIJIMA, DDS

701 N 182nd Street, Suite 102
Shoreline, WA 98133

Phone: (206) 542-7600 **Fax:** (206) 542-7727 **Email:** info@shoreline-dentist.com

Signature: _____ Date: _____

Relationship to patient (if signed by authorized representative): _____

** BELOW TO BE COMPLETED AND RETURNED BY PREVIOUS DENTIST **

Date of last visit to your office: _____

Date of last Full Mouth X-rays: _____

Date of last Pano:_____

Date of last series of Bitewing/Periapical X-rays: _____

Scaling and root planing dates: _____

Date of last Prophy D1110 or Perio Maintenance D4910 (please circle which): _____

**Please send most recent FMX, Pano, BWs/PAs, perio chart,
and records of implant placement and/or restoration (if applicable).**

Thank you!