Jayna Sekijima, DDS

701 N 182nd St. Suite 102, Shoreline, WA 98133
P 206-542-7600 | F 206-542-7727 | info@shoreline-dentist.com

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. _______

□ Male □ Female By what name would you like us to call you? ____

Date of Birth ______ / ______ /__________ 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 _______________________

□ Male □ Female Date of Birth ______ / ______ /__________

Street Address ____ Home Phone ________________________

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?

____

Request for Confidential Communication

As my dental care provider, I give permission for you to do the following:

	YES	NO
Contact me at home	□	□
Contact me via cell phone	□	□
Contact me at work	□	□
Contact me via e-mail	□	□
Leave messages on my home answering machine	□	□
Leave messages on my cell phone voicemail	□	□
Leave messages on my work voicemail/answering machine	□	□

Insurance

Subscriber's Name ____________________________________ Relationship to the Patient _____________________

Subscriber's Date of Birth ____ / ____ / ______ SS# / ID ____________________________________

Insurance Company ________________________________ Phone Number ___________________________________

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 ____ / ____ / ______ SS# / ID ____________________________________

Insurance Company ________________________________ Phone Number ___________________________________

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 never had adequately answered for you?

____

____

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

701 N 182nd St. Suite 102, Shoreline, WA 98133

P 206-542-7600 | F 206-542-7727 | info@shoreline-dentist.com

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of the Statement of Privacy Practices for the 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 ______________

DENTAL RECORDS RELEASE AUTHORIZATION FORM

I, ____, authorize ____
(Patient name) (Previous dentist/dental office)

to release copies of all information contained in my dental files. This may include, but will not be limited to, medical and dental history, radiographs, description of treatment rendered, diagnosis and prognosis, further treatment deemed necessary, and other notes and charting.

Patient signature: ____ **Date:** ___________________________

Patient name: ____

Patient D.O.B.: ____

Please send to:
Jayna Sekijima, DDS
701 N 182nd St. Suite
102 Shoreline, WA
98133
Phone: (206) 542-7600
Fax: (206) 542-7727
Email: Info@shoreline-dentist.com