Rainier Ave. Dental

5425 Rainier Ave S • Seattle, WA 98118
206-725-3667 info@rainieravedental.com
Dr. Jiyon Kim and Dr. Sang C. Kim

New Patient Registration

Name_____ Address_____

City_____ Zip_____ Home# _____Cell# _____Work# _____

Sex ___**F** ___**M** Marital Status **S M D** Birth date _____ **SS#**_____-_____-_____
(Circle one) **(Only needed if used as insurance ID#)**

Email address _____

Patient Employed by_____ Business Address_____

In case of emergency notify, _____ Phone_____
(Name and relationship)

Whom may we thank for referring you? _____

Dental Insurance

Primary	Secondary
SUBSCRIBERS'S NAME	SUBSCRIBERS'S NAME
DATE OF BIRTH	DATE OF BIRTH
INSURANCE COMPANY	INSURANCE COMPANY
SUBSCRIBER #	SUBSCRIBER #
GROUP #	GROUP #
EMPLOYER	EMPLOYER
OCCUPATION	OCCUPATION

Dental History

Previous Dentist _____

Address _____(_____) _____
Number Street City State Zip Telephone

Date of last dental visit_____ Date of last dental x-rays _____ Reason for leaving _____

Are your teeth affecting your general health?	YES	NO	Have you experienced prolonged bleeding or slow healing after a tooth extraction?	YES	NO
Are you satisfied with your teeth and gums?	YES	NO			
Do you have sore or sensitive teeth?	YES	NO	Have you had orthodontic treatment (braces)?	YES	NO
Have you ever been treated for periodontal disease?	YES	NO	Are you aware of grinding or clenching your teeth day or night?	YES	NO
Have you ever had serious complications with dental treatment?	YES	NO	Have you neglected regular dental visits in the past?	YES	NO
Do you want your teeth to be whiter?	YES	NO	Are you dissatisfied with the appearance of your teeth?	YES	NO

How often do you brush? _____How often do you floss? _____ **Tell us about your dental health**: _____

_____

Medical History

Physician Name: _____ Phone: _____ Date of last health care exam: ____/____/____

What was the exam for? _____ Have you been hospitalized in the last 5 years? (Please circle) **NO YES**

If yes, reason: _____

Medications:

Are you taking blood thinners such as aspirin or coumadin? _____

Are you currently taking any medications, prescription or over the counter drugs? (Please circle) **NO YES** If yes, please list: _____

_____

Are you required to Pre-medicate before dental treatment? (Circle) **NO YES** if yes, reason _____

Are you a smoker? (Circle) **NO YES** If so, how much per day and for how long? _____

Are you taking or have you ever taken fosomax or any biophosphonate related drugs? (Circle) **NO YES**

Please check any of the following which you have now or have had in the past. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked questions concerning your response.

__HIV infection/AIDS
__ HIV positive/AIDS
__Anemia
__Blood Transfusion
__Headaches
__Artificial joints
__Asthma
__Back problems
__Blood Disease
__Cancer
__Chemical Dependency
__Chemotherapy
__Circulatory Problems
__Cough, Persistent
__ Cosmetic Surgery
__ Artificial heart valves
__Radiation Therapy
__Liver Disease (Jaundice)
__ Emphysema
__ Fainting
__ Seizures
__ Bruise Easily
__Glaucoma
__Sickle Cell Disease
__Heart Attack
__Respiratory Disease
__Heart Murmur
__Rheumatic/Scarlet Fever
__Heart Problems
__Mitral Valve Prolapse
__Diabetes
__Thyroid Problem
__High/low Blood Pressure
__Tuberculosis
__ Fever Blisters/Cold Sores
__ Heart Pacemaker
__ Arthritis/Rheumatism
__Psychiatric Care
__Venereal Disease
__ Anxiety Disorder
__ Lupus
__Epilepsy
__ Shingles
Describe: _____
__Shortness of Breath
__Kidney Disease
__Hemophilia
__Swelling, feet/ankle
__ Stomach Ulcers
__Hepatitis (type) _____
__Tobacco Habit

Is there anything else you would like us to be aware of? _____

Are you being treated for any illness now? (Circle) **NO YES** if yes, please explain: _____

_____

Please list any allergies you have: _____

Women: Are you pregnant? **NO YES**
If no, are you planning a pregnancy in the near future? **NO YES**
Are you nursing? **NO YES**
Are you taking birth control pills? **NO YES** if yes, please list: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release information to you. I will notify the dentist of any changes in my health or medications.

Patient's Signature: _____ **Date**: _____/_____/_____

Financial Policy Agreement
Optional Payment Terms:

1. **2 Payment Option**: We offer a two-payment option for Crown, Bridge, and Denture treatment. We ask that you pay one-half of your co-payment at the first appointment and the balance due at the second appointment.
2. **Discount Plans:** Patients on the AmeriPlan or Carington dental plans will not receive any additional discounts.
3. **Care Credit**: We offer our patients, upon approval, a financing program with no down payment, several different payment options which are customized to your individual needs and no prepayment penalty. Please ask for an application.

Payments are due at the time services are rendered.

To maintain the practice operations and to prevent potential misunderstandings, we ask patients to accept and adhere to financial arrangements regarding their dental treatment. We accept cash, checks, ATM cards, and all major credit cards.

Acknowledgment Receipt of Notice of Privacy Practices

I, _____, have received a copy of the Rainier Ave Dental Privacy Practices,
(Print Name)
Financial Policy and I authorize the assignment and release form.

_____ _____
Patient's Signature *Date*

_____ _____
If patient is a minor: Parent/Guardian's Signature *Date*

Acknowledgement of Privacy Practices

Rainier Ave Dental- Seattle, WA

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, 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 services

Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*. Importantly the updated 9-23-13 version of the NOPP reflecting the OMNIBUS rule.

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.

Patient Name:
_____Date:_____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

Additional Disclosure Authority: (concluded with discussion RE: patient etc.)

OTHER-SPECIFY	Names	Signatures	ID

For Office Use Only:

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

- The patient refused to sign
- Communication barriers
- Emergency situation
- Other

Dental Records & Radiograph Release Form

Date:_____

Doctor: _____

- Chart Notes
- X-Rays
- Perio Chart

I authorize the release of dental records and request that they are transferred to:

Rainier Ave Dental
5425 Rainier Ave S.
Seattle, WA 98118
P: 206.725.3667 F: 206.725.3838
Email: info@rainieravedental.com

Patient name: _____

DOB: _____

Patient, Parent or Guardian Signature:_____