STEVE C. YANG DDS
JESSICA K. TSUKAMOTO DDS

1128 Kirkland Avenue Northeast
Renton, WA 98056

PATIENT INFORMATION

Name_____ SSN_____ Birthdate_____
Address_____ City_____ State_____ Zip_____
Home Phone_____ Work Phone_____
Cell Phone_____ Email_____
How may we contact you? Please check all that apply:
□ Home □ Work □ Cell □ Email □ Text Message
Whom may we thank for referring you? _____

IN CASE OF EMERGENCY NOTIFY:

Name_____ Relationship_____
Telephone_____ City, State_____

PERSON RESPONSIBLE FOR THIS ACCOUNT

□ Self (Same as above)
□ Other:
Name_____ Relationship to Patient_____
Address_____
Home Phone_____ Cell Phone_____ Work Phone_____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Company_____ Group Number_____
Address_____ City_____ State_____ Zip_____
Policy Holder/Relationship to Patient_____
Policy Holder SSN/ID Number_____ Policy Holder Birthdate_____

Secondary Insurance

Insurance Company_____Group Number_____
Address_____City_____State_____Zip_____
Policy Holder/Relationship to Patient_____
Policy Holder SSN/ID Number_____Policy Holder Birthdate_____

I grant permission to Steve C. Yang, D.D.S., Jessica K. Tsukamoto, D.D.S. and team to perform treatment as deemed professionally necessary. When local anesthetic is administered, I understand that the risks involve include heart palpitation, allergic reaction, hematoma, paresthesia or drug cross reaction.

<u>FINANCIAL AGREEMENT AND INSURANCE AUTHORIZATION</u>: All charges for treatment are the responsibility of the patient or insured. Outstanding balances over 60 days accrue interest of 1% per month.
I agree to be responsible for all charges for dental services and materials not paid for by my dental benefit plan. To the extent permitted under law, I authorize release of any information pertaining to my dental treatment which may be required to process a claim for payment. I authorize payment of insurance benefits to Dr. Steve Yang, DDS.

Patient/Guardian Signature **Date**

DENTAL AND MEICAL INFORMATION Blood Pressure Base_____

Reason for today's visit_____ Date of last cleaning/exam_____

Is the condition result of an accident? _____ If so, explain _____

Physician name_____ Date of last medical exam_____

Are you currently under the care of a physician? _____ If so, explain _____

Physician Phone _____ City _____ State _____

Recent surgeries/hospitalizations: _____

Prescription Medication		Over the Counter/Herbal/Vitamins	
1._____	for? _____	1._____	for? _____
2._____	for? _____	2. _____	for? _____
3. _____	for? _____	3. _____	for? _____

HAVE YOU EVER TAKEN ANTIBIOTICS OR PREMEDICATION FOR A DENTAL APPOINTMENT?_____

PLEASE MARK ANY THAT APPLY	YES	PLEASE MARK ANY THAT APPLY	YES
Are you apprehensive about dental treatment?	□	Chew on one side of your mouth?	□
Problem with previous dental treatment?	□	Lip or cheek biting?	□
Do you have dental implants?	□	Do you smoke cigarette, pipe or cigar?	□
Do you wear dentures?	□	Clicking or popping jaw, jaw pain or tiredness?	□
Does food catch between your teeth?	□	Do you clench or grind?	□
Dissatisfied with the appearance of your teeth?	□	Does the jaw get stuck so you can't open easily?	□
Do you have sensitivity to hot/cold/sweets?	□	Slow healing sores in or about your mouth?	□
Do you have pain in the face, jaws, throat area?	□	Do you have dry mouth?	□

MEDICAL HEALTH HISTORY:

	YES		YES		YES
HEART PROBLEM		BLOOD PROBLEMS		Cancer or tumor	□
Chest pain	□	Easy bruising	□	Do you drink alcohol	□
Shortness of breath	□	Abnormal bleeding	□	If so, how much? _____	
Blood pressure problem	□	Blood disease (anemia)	□	Hepatitis, jaundice, or liver	
Heart murmur	□	Blood transfusion	□	trouble	□
Heart valve problem	□	ASTHMA/ALLERGY		Herpes or other STD	□
Taking heart medication	□	Inhaler	□	HIV positive or AIDS	□
Pacemaker	□	JOINT OR BONE PROLBEMS		Glaucoma	□
Rheumatic fever	□	Arthritis	□	Do you wear contacts	□
Artificial heart valve	□	Joint replacement	□	History of alcohol/drug abuse	□
		Bisphosphonate Meds	□	Thyroid Problems	□
WOMEN ONLY		TUBERCULOSIS OR		Stroke	□
Taking osteoporosis medication		RESPIRATORY ISSUES	□	Headaches	□
Taking hormones/contraceptive		Persistant cough/swollen		How often?_____	
Are you pregnant?		glands	□	Other:_____	
If so, delivery date _____		Fainting, seizure, epilepsy	□	_____	
Are you nursing		DIABETES	□		

ALLERGIES	YES		YES
Local anesthetics such as Novocain	□	Aspirin, acetaminophen or ibuprofen	□
Penicillin or other antibiotics	□	Codeine, Demerol, or other narcotics	□
Sulfa Drug	□	Reaction to metals	□
Barbituates, sedatives, or sleeping pills	□	Latex or rubber dam	□

Other _____

Patient or Guardian Signature **Date** **Provider Signature** **Date**