Dental & Holistic Health

Welcome to our office, **Jeanette Midori Okazaki, DDS., Inc.** *We feel you will be pleased with our unique dental services, offering progressive quality dentistry with a holistic approach, acupuncture, mercury-free fillings, digital x-rays, and special emphasis on Tender Loving Care. In keeping with holistic philosophy, we begin each day with conscious breath work, meditation and creative visualizations before greeting our first patients.*

PATIENT INFORMATION

Please complete this confidential personal history form.

Patient's name: _____ Home phone: (___) _____

Home address: _____ City: _____ Zip: _____

Social Security Number (SSN#): _____ Birth date: _____

Employer: _____ Occupation: _____ How long? ___

Business address: _____ Name of spouse/partner: _____

Business phone: (___) _____ Daytime phone: (___) _____ Cell phone: (___) _____

Email: _____

What is the major reason you are here today? _____

_____

How did you come to choose our office? _____

Person responsible for this account other than above named patient:

Responsible person: _____ Relationship to patient: _____

Birth date: _____ SSN#: _____ Phone: (___) _____

Address (if different than above) _____ Phone: (___) _____

Responsible party's employer: _____ Occupation: _____

For patients covered by dental insurance:

Subscriber's name: _____ Birth date: _____ SSN#: _____

Subscriber's employer: _____ Business address: _____

Insurance company: _____ Group/policy #: _____ Phone: (___) _____

Patient's relationship to subscriber: ☐ Self ☐ Spouse/partner ☐ Dependent

If you are covered by more than one plan please complete the following:

Subscriber's name: _____ Birth date: _____ SSN#: _____

Patient's relationship to subscriber: _____ Employer: _____

Insurance company: _____ Group/policy #: _____ Phone: (___) _____

In case of an emergency, whom do we contact? _____

Relationship: _____ Phone: (___) _____

Consent: *This is to certify that I, the undersigned, consent to the performing of dental procedures which may be decided upon to be necessary or advisable, and to the use of local anesthetic as may be deemed advisable by the dentist. I hereby authorize the dentist to release any and all dental and medical information to the above-named insurance carrier for purposes of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoked.*

I understand and agree to the above. Signature: _____ Date: _____

Appointment Policy: *In this age of fast paced lifestyles and technology, we rarely reach our patients personally, thereby making it impossible to confirm. The ever increasing number of voice-mail, pagers, and answering machines have made it necessary to set an office policy requiring patients to be responsible for their appointments. All appointments are confirmed at the time of scheduling. We schedule special time for each patient and require a 48 hour notice for all changes in appointments, otherwise, a $50.00 fee per scheduled hour will be charged.*

I understand and agree to the above. Signature: _____ Date: _____