

**CHRSTINE SHIGAKI D.D.S., P.L.L.C.**

BELLTOWN DENTAL  
2623 WESTERN AVENUE  
SEATTLE, WA 98121

**I. Patient Registration Information**

**A. Patient Information:**

Legal Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Pronouns: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address/City/State/Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Employer Address/City/State/Zip: \_\_\_\_\_

Occupation/Profession: \_\_\_\_\_ Work Phone: \_\_\_\_\_

If Applicable, referred by: \_\_\_\_\_ Relationship: \_\_\_\_\_

In case of Emergency, please contact: \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number(s): \_\_\_\_\_

*Office Notes:* \_\_\_\_\_

**B. Parent/Guardian or Responsible Party (if applicable):**

Not Applicable      Parent      Guardian      Other (specify): \_\_\_\_\_

Legal Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Pronouns: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address (if different): \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Employer Address/City/State/Zip: \_\_\_\_\_

Occupation/Profession: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**C. Preferred Method of Contact: please indicate your preferred methods of being contacted:**

The best way to reach me is by (select as many as you like):

Telephone      Cell phone      E-mail      Postal Service      Other:

**D. Financial Responsibility: our financial policy is to receive full payment at the time of service, unless specific financial arrangements have been previously agreed upon prior to receiving treatment.**

1) I prefer to pay for my balance due, or my estimated insurance co-pay:

- a. by check or cash
  - b. by credit card
  - c. by debit card
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2) I would like to keep a credit card on file with Belltown Dental (if yes, we will provide a form, kept secured, to record your information and for you to specify the conditions use).

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

3) " I have received A Notice of Privacy Practices for Belltown Dental. This is my authorization and consent. If this patient is a minor or unable to provide a signature, I am able to do so in his or her behalf."

Change requests: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**E. Patient Photo Release**

I hereby authorize Belltown to take photographs and videos of my teeth, jaws, and face. I understand that the photographs and videos will be used as a record of my care and may be used for communication with other health care professionals, educational publications, and educational lectures.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_