BELLTOWN DENTAL
2623 WESTERN AVENUE
SEATTLE, WA 98121

CHRISTINE SHIGAKI D.D.S., P.L.L.C.

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:

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: