KENYU TAKAMOTO DDS, MSD
1811 156th Ave NE #1
Bellevue, WA 98007
(425)746-8676

Patient Information

Name ______________ (Last) ______________ (First) ______ (MI) (printed please) SS# ____-____-______ Birth Date ______________ (M / D / Y) Sex ______ (M / F)

Parent/ Spouse ______________________________ SS# ____-____-______ Birth Date ______________

Home Address ______________________________ (*NO* P.O Box) City ______________ Zip ______

Phone# (home) (______)______________, (work) (______)______________ Ext:______

(cell) (______)______________, E-mail Address ______________________

Guarantor's Employer ______________________________ Phone# (________)______________

Company Address ______________________________ City ______________ Zip ______

Dental Insurance Company ______________________________ Phone# (________)______________

Group# ______________ Subscriber# ______________

Person to contact in case of emergency ______________________ Phone# (______)______________

Foreign student, please fill in home address ______________________________________

Financial Agreement and Authorization for treatment

I authorize treatment of the person named above and agree to pay all fees and charged for such treatment. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentment thereof, unless credit arrangements are agreed upon in writing within thirty days of billing date. In the event it should become necessary to place for collection and unpaid balance due for services rendered to me or my family, I/we agree to pay collection fees, and should legal action to be filed, reasonable attorney fee and any other costs the courts determine proper.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or the dependency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. If need be, I agree to pay rebilling charges of 1.5% per month for balance over 30 days and any broken appointment charges when less than 48 hours notice has been given.

A copy of this agreement is as valid as the original.

The above information is for the purpose of obtaining credit and is warranted to be true. I authorize creditor or his agent make a credit investigation, including employment verification.

Notice; Do not sign this agreement before you read and agree to the condition set forth. You are entitled to a copy of the agreement at the time you sign. Keep it to protect your rights.

Signature: ______________________________ Date: ______________

(Parent or legal guardian if patient is minor, power of attorney must be represented, if necessary.)