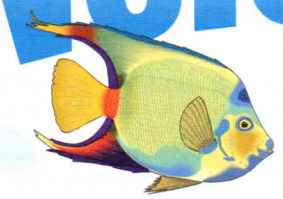
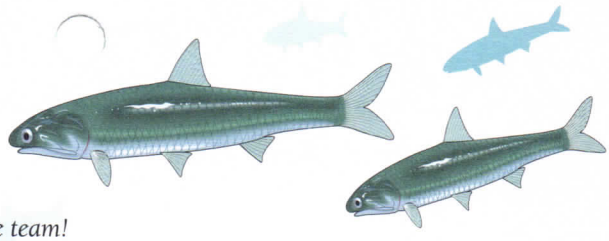
Welcome





Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # _____
SS#/SIN _____
Date _____

Patient Information (CONFIDENTIAL)

Patient's Sex ☐ *F* ☐ *M*

Name _____ *Birthdate* _____ *Home Phone* _____

Address _____ *City* _____ *State/Prov.* _____ *Zip/P.C.* _____

Email _____ *Cell Phone* _____

Do you prefer to receive calls at your: ☐ *Home* ☐ *Work* ☐ *Cell Phone*

Check Appropriate Box: ☐ *Minor* ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Separated*

If Student, Name of School/College _____ *City* _____ *State/Prov.* _____ ☐ *Full Time* ☐ *Part Time*

Patient or Parent/Guardian's Employer _____ *Work Phone* _____

Business Address _____ *City* _____ *State/Prov.* _____ *Zip/P.C.* _____

Spouse or Parent/Guardian's Name _____ *Employer* _____ *Work Phone* _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ *Phone* _____

Responsible Party

Name of Person Responsible for this Account _____ *Relationship to Patient* _____

Address _____ *Home Phone* _____

Email _____ *Cell Phone* _____

Driver's License# _____ *Birthdate* _____ *Financial Institution* _____

Employer _____ *Work Phone* _____ *SS#/SIN* _____

Is this Person Currently a Patient in our Office? ☐ *Yes* ☐ *No*

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ *Cash* ☐ *Personal Check* *Credit Card* ☐ *VISA* ☐ *MasterCard* ☐ *I wish to discuss the office's payment policy.*

Insurance Information

Name of Insured _____ *Relationship to Patient* _____

Birthdate _____ *SS#/SIN* _____ *Date Employed* _____

Name of Employer _____ *Union or Local#* _____ *Work Phone* _____

Address of Employer _____ *City* _____ *State/Prov.* _____ *Zip/P.C.* _____

Insurance Company _____ *Group#* _____ *Policy/ID#* _____

Ins. Co. Address _____ *City* _____ *State/Prov.* _____ *Zip/P.C.* _____

How Much is your Deductible? _____ *How Much Have You Used?* _____ *Max. Annual Benefit* _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ *Yes* ☐ *No* *IF YES, COMPLETE THE FOLLOWING:*

Name of Insured _____ *Relationship to Patient* _____

Birthdate _____ *SS#/SIN* _____ *Date Employed* _____

Name of Employer _____ *Union or Local#* _____ *Work Phone* _____

Address of Employer _____ *City* _____ *State/Prov.* _____ *Zip/P.C.* _____

Insurance Company _____ *Group#* _____ *Policy/ID#* _____

Ins. Co. Address _____ *City* _____ *State/Prov.* _____ *Zip/P.C.* _____

How Much is your Deductible? _____ *How Much Have You Used?* _____ *Max. Annual Benefit* _____

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐
9. Do you have or have you had any of the following?		

	Yes	No
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other _____		
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
13. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other _____	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? If yes, date of placement _____	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

Payment is due in full at the time of treatment *unless prior arrangements have been approved.*
This office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company.
I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

X _____

Signature of patient (or parent/guardian if minor) *Date*

KAHANA FAMILY DENTAL CENTER
10 Hoohui Rd, Suite 208, Lahaina, HI 96761
(808) 665-0888
KahanaFamilyDental@hotmail.com

Statement of Privacy Practices

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principal concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect our obligations and your rights.

Protecting your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Hawai'i. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given or disclosed to anyone - even family members - without your consent or written authorization. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our office electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality, integrity, and access to your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Healthcare Information (PHI)

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is

KAHANA FAMILY DENTAL CENTER
10 Hoohui Rd, Suite 208, Lahaina, HI 96761
(808) 665-0888
KahanaFamilyDental@hotmail.com

deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Healthcare Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing or fund-raising purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, text messages, emails and postcards unless you direct us otherwise. We will never use, disclose, sell, or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.
Any breach in the protection of your personal health information, including unauthorized acquisition, access, use, or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI.

Your Rights as our Patient

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.
An expanded, and complete copy of our Statement of Privacy Practices is available for your review.

KAHANA FAMILY DENTAL CENTER
10 Hoohui Rd, Suite 208, Lahaina, HI 96761
(808) 665-0888
KahanaFamilyDental@hotmail.com

Acknowledgment of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Kahana Family Dental Center, LLC. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and responsibilities and duties of this office with respect to my protected health information.
Kahana Family Dental Center, LLC reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting them to be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, Protected Healthcare Information cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

Spouse only: ( )Yes ( )No
OR
Any member of my immediate family (Spouse, Children, Children`s Spouses): ( )Yes ( ) No
Any member of my extended family (Parents, Grandchildren): ( ) Yes ( ) No
If so, who?
Other:

KAHANA FAMILY DENTAL CENTER
10 Hoohui Rd, Suite 208, Lahaina, HI 96761
(808) 665-0888
KahanaFamilyDental@hotmail.com

PLEASE COMLETE AND SIGN BELOW

Patient`s name (please print) _____

Patient`s signature (please print) _____

Patient`s personal representative (please print) _____

Personal Representative`s signature _____

Personal Representative`s Phone number: _____

_____
Date

OFFICE USE ONLY BELOW THIS LINE

We attempted to obtain written acknowledgment of Receipt of Statement of Privacy Practices, on _____ but acknowledgment could not be obtained because:
(date)

- Patient refused to sign
- Patients need more time to review Statement
- Patient wanted to consult another person before signing
- Patient physically unable to sign
- An emergency situation prevented us from obtaining acknowledgment
- Communication barriers prohibited obtaining the acknowledgment
- Other (please specify): _____