WAILUKU
DENTAL GROUP

PATIENT INFORMATION

Patient's Last Name | First | Middle Initial | Social Security Number

What name would you like to be called by in this office | Date of Birth | Age | Sex | Marital Status

Mailing Address | City | State | Zip | Home Telephone Number

Residence Address | City | State | Zip | Business Telephone Number

Cell Phone:_____ Email_____

Occupation | Employer | Second Occupation | Second Employer

Who may we thank for referring you to our office?_____

Spouse/Responsible Party Information

Spouse or Responsible Party Last Name | First | Middle Initial | Social Security Number

Mailing Address | City | State | Zip | Home Telephone Number

Occupation | Employer | Date of Birth | Business Telephone Number

Emergency Contact Last Name | First | Middle Initial | Relationship to Patient

Mailing Address | City | State | Zip | Home Telephone Number

Dental Insurance Information-Primary Coverage

Insured's Name | Insured's Employer | Social Security Number

Insurance Company Name | Address | City | State | Zip

Membership/Group/Plan Numbers | Insurance Effective Date

Dental Insurance Information-Secondary Coverage

Insured's Name | Insured's Employer | Social Security Number

Insurance Company Name | Address | City | State | Zip

Membership/Group/Plan Numbers | Insurance Effective Date

PRINTED NAME/SIGNATURE:_____ ***DATE***_____

WAILUKU DENTAL GROUP

PATIENT CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving.

_____

Physicians Name, Address & Phone Number *Date of your last physical*

******Is Premedication/Antibiotics required by your physician prior to dental visits? YES OR NO***

If yes, what antibiotics and dosage? _____

Do you have or have you ever had the following:

	YES	NO		YES	NO		YES	NO
Heart Valve Problems			Joint Replacement - **When?**			Tuberculosis		
Rheumatic Heart disease or Rheumatic Fever			Organ Transplant - **When?**			Epilepsy		
Congestive Heart Failure			History of Cancer **Type**:			Stomach Ulcer		
Heart Attack - **When?**			Leukemia			AIDS or HIV Infection		
Artificial Valves - **When?**			History Chemotherapy or Radiation			Sexually Transmitted Diseases		
Heart Surgery - **When?**			Undergoing Cancer Treatment			Anemia or Blood Disorder		
Heart Trouble or Angina			Sjogren's Syndrome			Have you had any abnormal bleeding		
Heart Murmur			Oral Cancer			Are you taking depression or bipolar medication		
Pacemaker			HPV/Human Papillomavirus			Are you taking aspirin		
Stroke - **When?**			Lung or breathing problems			Are you taking blood thinners ie Coumadin or Plavix		
High Blood Pressure			Asthma			Do you use tobacco/vape products		
Low Blood Pressure			Sinus Trouble			Do you consume alcohol		
Prediabetes			Arthritis or rheumatism			Do you use cocaine or other drugs		
Diabetes			Osteoporosis			***Women only:***		
Chronic Kidney Disease			Thyroid problems			Are you pregnant or think you may be		
Renal Dialysis			Seizures			Are you nursing		
Hepatitis, Jaundice or Liver Disease			Glaucoma			Are you taking birth control pills		

Are you allergic to or have you had reactions to:

	YES	NO		YES	NO
Local Anesthetics like novocaine or epinephrine			Aspirin		
Penicillin			Sulfites		
Erythromycin			Sulfa drugs		
Other known allergies: List:					

I certify that the information listed is complete and accurate.

PRINTED NAME/SIGNATURE: _____ ***DATE*** _____

WAILUKU
DENTAL GROUP

PATIENT CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE

Are you currently under the care of a physician? Explain: _____

_____

Has there been any changes in your general health within the past year? Explain:

_____

_____

Have you been hospitalized for any surgical operation or serious illness, especially within the last 6 months?

Explain: _____

_____

Any other medical problems? Explain: _____

_____

_____

Are you taking any prescription medicine (s): Please list: _____

_____

_____

Are you taking any non-prescription medicine (s): Please list: _____

_____

_____

OFFICE USE ONLY
COMMENTS BY PROVIDER:
PROVIDER INITIALS

PRINTED NAME/SIGNATURE: _____ ***DATE*** _____

WAILUKU DENTAL GROUP

DENTAL HISTORY

How would you rate the condition of your mouth? ◯ Excellent ◯ Good ◯ Fair ◯ Poor

Previous Dentist_____ How long have you been a patient? _____ Months/years

Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____

Date of most recent treatment (other than a cleaning) ___/___/___

I routine see my dentist every □ 3 mo. □ 4 mo. □ 6 mo. □ 12 mo. □ Not routinely

What is your immediate concern?_____

PERSONAL HISTORY	**YES**	**NO**
Are you fearful of dental treatment? How fearful, on a scale of 1(least) to 10 (most) (_____)_____	◯	◯
Have you had an unfavorable dental experience? _____	◯	◯
Have you ever had complications from past dental treatment? _____	◯	◯
Have you ever had trouble getting numb or had any reactions to local anesthetic? _____	◯	◯
Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____	◯	◯
Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? _____	◯	◯
GUM AND BONE	**YES**	**NO**
Do your gums bleed sometimes or are they ever painful when brushing or flossing? _____	◯	◯
Have you ever been treated for gum disease, had scaling and root planing, or been told you have lost bone around your teeth? _____	◯	◯
Have you ever noticed an unpleasant taste or odor in your mouth? _____	◯	◯
Is there anyone with a history of periodontal disease in your family? _____	◯	◯
Have you ever experienced gum recession, or can you see more of the roots of your teeth? _____	◯	◯
Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____	◯	◯
Have you experienced a burning or painful sensation in your mouth not related to your teeth?_____	◯	◯
TOOTH STRUCTURE	**YES**	**NO**
Have you had any cavities within the past 3 years? _____	◯	◯
Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____	◯	◯
Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____	◯	◯
Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____	◯	◯
Do you have grooves or notches on your teeth near the gum line? _____	◯	◯
Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	◯	◯
Do you frequently get food caught between any teeth? _____	◯	◯
BITE AND JAW JOINT	**YES**	**NO**
Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	◯	◯
Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? _____	◯	◯
Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____	◯	◯
In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? _____	◯	◯
Are your teeth becoming more crooked, crowded, or overlapped? _____	◯	◯
Are your teeth developing spaces or becoming more loose? _____	◯	◯
Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?____	◯	◯
Do you place your tongue between your teeth or close your teeth against your tongue? _____	◯	◯
Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	◯	◯
Do you clench or grind your teeth together in the daytime or make them sore? _____	◯	◯
Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?_____	◯	◯
Do you wear or have you ever worn a bite appliance?_____	◯	◯
SMILE CHARACTERISTICS	**YES**	**NO**
Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)?	◯	◯
Have you ever bleached (whitened) your teeth? _____	◯	◯
Have you felt uncomfortable or self conscious about the appearance of your teeth?_____	◯	◯
Have you been disappointed with the appearance of previous dental work?_____	◯	◯

PRINTED NAME/SIGNATURE:_____ ***DATE***_____

WAILUKU DENTAL GROUP

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 1, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

- Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
- Payment: We may use and disclose your health information to obtain payment for services we provide to you.
- Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

WAILUKU
DENTAL GROUP

Required by Law: We may use or disclose your health information when we are required to do so by law

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized Federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $25.00 for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr. Heather Hearon 808-244-8808

WAILUKU
DENTAL GROUP

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information, I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers, (insurance carriers etc.).
- Conduct normal healthcare operations.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this practice has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this practice at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Print Patient Name | Print Name of Guardian if Minor | Relationship

Signature | Date

Office Use Only

I attempted to obtain the patient's (guardian's) signature in acknowledgement of the *Notice of Privacy Practices,* but was unable to do so as documented below.

Print Name and initial | Date

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

WAILUKU
DENTAL GROUP

Appointment Policy

Appointments are required for all treatment in our office, including new patients and emergencies. Every effort is made by the dental staff to see patients in a timely manner and inform patients if there is a need to change or adjust their appointment time.

EMERGENCY APPOINTMENTS: If you have what you believe to be a dental emergency, please contact us as soon as possible, preferably by telephone, so that we may properly assign an appointment time to handle your problem. Please be aware that we may have several emergencies at the same time. If we are unable to see you immediately, it is because proper triage and scheduling prevents it. If we are unable to see you in a timely manner, we will refer you to a colleague, specialist, or emergency medical center.

BROKEN APPOINTMENTS: We do not over-book our schedule. This means your appointment time is reserved especially for you. If you do not come, not only is your own care delayed, but no one else is able to be treated during that time. When appointments are not kept, dental costs increase for everyone and emergency patients that may have been treated must needlessly wait.

If you absolutely must reschedule, please give at least 24 hours notice (before 9 am Thursday for Monday appointments) to avoid possible broken appointment fees. In some cases, especially for large appointment space, you may be asked to give greater notice.

A cancelled or broken appointment without 24 hour notice will incur a minimum charge of $40.00 (depending on the length of the appointment, this fee may be higher for longer length appointments), which is the patient's financial responsibility as dental insurance will not cover broken appointment fees.

Any broken appointment charges will need to be taken care of before you will be able to reschedule for another appointment.

Multiple cancellations and broken appointments may result in dismissal from Wailuku Dental Group.

DEPOSIT TO RESERVE APPOINTMENTS: Occasionally we may ask you to reserve your appointment with a deposit toward your treatment, especially for longer appointments. This allows us to exclusively reserve your appointment time as well as helps patients spread out the expense of treatment over several visits if necessary. This deposit is fully refundable if the cancellation policy of 48 hours notice is maintained by our patients. If you fail to attend their appointment or give notice that they need to reschedule, the broken appointment fee will be assessed and some or all of the deposit will be lost, and you will need to make another deposit to make another appointment for that amount of time.

MULTIPLE APPOINTMENTS FOR FAMILY MEMBERS: Occasionally, patients request appointments to have several family members seen on the same day in concurrent or successive time slots. It is our pleasure to honor this request when possible. Please be aware, however, that for each family member that is unable to keep his or her appointment (without advance notification as noted under the Broken Appointment heading above), charges will be assessed after the first occurrence. If broken appointments continue in a family, we reserve the right to schedule members separately or refer to another practice.

LATE ARRIVAL TO APPOINTMENTS: If you arrive late to your scheduled appointment, it will be at the discretion of the provider if he/she can still accommodate you. Priority will be given to patients who arrive on time and you may have to be worked on in between them. One or two late patients cause the entire daily schedule to fall behind.

PRINTED NAME/SIGNATURE:_____ ***DATE***_____

WAILUKU
DENTAL GROUP

FINANCIAL GUIDELINES

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

INSURANCE:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf. Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

We are a participating provider of HDS & Delta Dental, with the exception of HDS Medicare Advantage. Patients with these types of insurance need only pay their patient share or co-pay and any non-covered services. All other insurance companies may be processed through our office on a company by company basis as an out-of-network office.

We are NOT contracted with HDS Medicare Advantage, and any patients with this insurance are not able to utilize the medicare plan benefits at our office. All fees for services rendered at our office will be the responsibility of the patient at time of service.

PAYMENT:

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made. For certain procedures, payment options may be available through our financial department.

UNPAID BALANCE over 30 days old will be subject to a monthly interest of 1.5%. If payment is delinquent, the patient will be responsible for payment of collection, attorney's fees, and court costs associated with the recovery of the monies due on the account.

MISSED APPOINTMENTS:

Unless we receive notice of cancellation 24 hours in advance, you will be charged a minimum of $40 (depending on the length of the appointment, the fee may be higher for longer length appointments). Please help us maintain the highest quality of care by keeping scheduled appointments.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

PRINTED NAME/SIGNATURE: _____ ***DATE*** _____