WAI'ALAE DENTAL CARE

Patient's
Name_____
Last First Middle

Marital Status: Single____ Married_____

Date of Birth_____ Female_____ Male_____

Social Security#_____
How do you wish
to be addressed?_____

Home Address_____

City_____ State_____ Zip_____

Home#_____ Work#_____

Cell#_____ Email_____

May we contact you (and leave messages) at the above phone numbers to confirm appointments? Y / N
If not, please specify appropriate phone numbers
_____

Who is responsible for this account? _____

Relationship to patient: _____

Primary Dental Ins:_____

Subscriber: _____ Subscriber birthdate:_____

Secondary Dental Ins:_____

Subscriber: _____ Subscriber birthdate:_____

Whom may we thank for this referral?

_____

Person to notify in case of emergency:_____

Relationship to patient:_____ Ph#:_____

INFORMED CONSENT:

1. Work to be done
   a. I understand that as a part of an examination at Wai'alae Dental Care ("WDC"), x-rays are required to properly diagnose my (or my child's) oral condition. If, however: (i) I refuse to take any x-rays (or not allow my child to take any x-rays) at WDC, or (ii) I do not provide WDC with x-rays approved by WDC, I understand that WDC will not be able to complete a full examination on me (or my child) and they will not be able to render an accurate diagnosis of my (or my child's) oral condition. I understand if I choose not to take any x-rays (or not allow my child to take any x-rays) and still proceed with treatment for myself (or my child) at WDC, it will be done at my own risk.

   Initials: _____

2. Broken appointments
   a. When I schedule an appointment for myself (or my child) at WDC, a specific amount of time will be reserved especially for me (or my child). If, however, I must re-schedule my (or my child's) appointment, I understand that I must inform WDC at least 48 (forty-eight) hours in advance.

   Initials: _____

3. Dental record request
   a. I understand that if I request that duplicate copies of my (of my child's) dental records and/or x-rays to be printed and sent to another General Dentist, I will be charged a $25.00 fee that will be due upon such request.

   Initials: _____

4. Receipt of Notice of Privacy Practices
   a. I have received and/or read and understand WDC's Notice of Privacy Practices for myself (or my child's).

   Initials: _____

RELEASE:

I authorize Wai'alae Dental Care ("WDC") to perform diagnostic procedures/treatment as may be necessary for proper dental care.

I authorize the release of any information concerning my (or my child's healthcare), advice, and/or treatment provided for the purpose of evaluating and/or administering claims for insurance benefits.

I authorize payment of insurance benefits directly to a doctor at WDC and/or WDC, otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services and that I am responsible for payments in full for all accounts. By signing this document, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part, by my dental care payor.

I agree that a service charge of 2% per month, 18% APR, will be added to balances over 30 days. I agree that I am liable for all legal and collection fees, which include an additional 50% of past due balances, and that accounts that are 60 days past due may be referred to a collection agency.

I attest to the accuracy of the information on this page.

Patient's or Guardian's Signature:_____ Date:_____

Patient's Name_____

Last **First** **Middle** **Date of Birth**

PATIENT MEDICAL HISTORY

Physician_____ Office Phone_____ Date of Last Exam_____

	Yes	No
1. Are you currently under medical treatment?	□	□
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 medications are you taking?	□	□
4. Have you ever taken Phen-Fen/Redux?	□	□
5. Do you use tobacco?	□	□
6. Do you use controlled substances?	□	□
7. Are you wearing contact lenses?	□	□
8. Have you ever taken Bisphosphonates (e.g. Fosamax) to treat Osteoporosis?	□	□

9. Are you allergic to, or have had any reactions to any of the following:	Yes	No
Local anesthetics (e.g. Novocaine, etc….)	□	□
Penicillin or any other Antibiotics	□	□
Sulfa Drugs	□	□
Barbituates	□	□
Sedatives	□	□
Iodine	□	□
Asprin	□	□
Any metals (e.g. nickel, mercury, etc….)	□	□
Latex rubber	□	□
Other (please list)_____		

10. Women only:	Yes	No
a. Are you pregnant or think you may be pregnant?	□	□
b. Are you nursing?	□	□
c. Are you taking oral contraceptives?	□	□

Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
AIDS or HIV Infection	□	□	Frequently Tired	□	□	Paralysis	□	□
Anemia	□	□	Glaucoma	□	□	Psychiatric problems	□	□
Angina	□	□	Hay Fever/Allergies	□	□	Radiation therapy	□	□
ARC	□	□	Heart attack	□	□	Recent Weight Loss	□	□
Arthritis	□	□	Heart murmur	□	□	Recurrent infections	□	□
Asthma	□	□	Heart surgery	□	□	Respiratory Problems	□	□
Blood disorder	□	□	Hemophilia	□	□	Rheumatic Fever	□	□
Brain disorder	□	□	Hepatitis A, B, or C	□	□	Seizures	□	□
Cancer	□	□	High Blood Pressure	□	□	Severe headaches	□	□
Cardiac Pacemaker	□	□	HIV	□	□	Sexually Transmitted Disease	□	□
Chemotherapy	□	□	Injury to face or head	□	□	Shingles	□	□
Chest Pains	□	□	Jaundice	□	□	Sinus problems	□	□
Congenital defect	□	□	Jaw lock (couldn't open or close)	□	□	Stomach Troubles/Ulcers	□	□
Depression	□	□	Jaw pain	□	□	Stroke	□	□
Diabetes	□	□	Jaw popping or clicking	□	□	Swollen Ankles	□	□
Difficulty breathing	□	□	Joint Replacement or Implant	□	□	Thyroid Problem	□	□
Ear pain	□	□	Kidney problems	□	□	Transfusion	□	□
Easily Winded	□	□	Leukemia	□	□	Tuberculosis	□	□
Emphysema	□	□	Liver disease	□	□	Ulcers	□	□
Epilepsy/convulsions	□	□	Low blood pressure	□	□	Veneral disease	□	□
Fainting	□	□	Mitral Valve Prolapse	□	□	Epilepsy/Convulsions	□	□
Fever blisters	□	□	Organ transplants	□	□	Other_____		

PATIENT DENTAL HISTORY

	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. Do you have frequent headaches?	□	□
8. Do you clench or grind your teeth?	□	□
9. Do you bite your lips or cheeks frequently?	□	□

	Yes	No
10. Have you ever had any difficult extractions?	□	□
11. Have you ever had any prolonged bleeding following extractions?	□	□
12. Have you had any orthodontic treatment?	□	□
13. Do you wear dentures or partials? If yes, specify date of placement_____	□	□
14. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	□	□
15. Do you like your smile?	□	□

Any other questions and/or concerns_____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Patient's/Guardian's Signature_____ Date_____

Dentist's Signature_____ Date_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR DENTAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS INFORMATION CAREFULLY.

Wai'alae Dental Care uses health information about you for treatment, payment and health care operations. Your health information is contained in paper and electronic records that are the property of Wai'alae Dental Care.

Use or Disclosure of Your Health Information

For Treatment:
Wai'alae Dental Care may use your health information to provide you with dental treatment and services. For example, information obtained by Wai'alae Dental Care will be included in your dental records that is related to your treatment. This information is necessary for Wai'alae Dental Care to determine what treatment you should receive. Wai'alae Dental Care will also record actions taken by them in the course of your treatment and note how you respond to the actions.

For Payment:
Wai'alae Dental Care may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a claim may be sent to your insurance carrier from Wai'alae Dental Care, in order for your insurance carrier to make payment based upon your dental benefits coverage. The information on the claim will include information that identifies you, your diagnosis and treatment or supplies used in the course of treatment.

For Health Care Operations:
Wai'alae Dental Care may use and disclose health information about you for operational purposes. For example, your dental information may be disclosed to your dental insurance carrier to:

- Evaluate the performance of your dentist;
- Assess the quality of care and outcomes in your cases and similar cases; and
- Learn how to improve our services to you.

Appointments:
Wai'alae Dental Care may use your information to provide appointment reminders or information about treatment alternatives or other dental-related benefits and services that may be of interest to you.

Required by Law:
Wai'alae Dental Care may use and disclose information about you as required by law. For example, your dentist may disclose information for the following purposes:

- For judicial and administrative proceedings pursuant to legal authority;
- To report information related to victims of abuse, neglect or domestic violence; and
- To assist law enforcement officials in their law enforcement duties.

Public Health:
Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury or disability, or for other health oversight activities.

Decedents:
Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Organ/Tissue Donation:
Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

Research:
Wai'alae Dental Care may use your health information for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research.

Health and Safety:
Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions:
Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of protected health information.

Workers Compensation:
Your health information may be used or disclosed in order to comply with laws and regulations related to Workers Compensation.

Your Health Information Rights

You have the right to:

- Request a restriction on certain uses or disclosures of your protected health information, however, your dentist is not required to agree to a requested restriction.
- Obtain a paper copy of the Notice of Privacy Practices upon request.
- Inspect and obtain a copy of your dental records held by Wai'alae Dental Care upon request.
- Request to amend your dental records.
- Request communications of your dental information by alternative means or at alternative locations.
- Revoke your authorization to use or disclose dental information except to the extent that action has already been taken.
- Receive an accounting of disclosures made of your information by Wai'alae Dental Care.

Complaints

You may submit complaints to Wai'alae Dental Care, insurance carrier and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Obligations of Your Dentist

Your dentist is required to:

- Maintain the privacy of protected health information;
- Provide you with this notice of its legal duties and privacy practices with respect to you health information;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed;
- Accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations; and
- Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

Your dentist reserves the right to change its privacy practices and to make new provisions effective for all protected health information it maintains. As notices are revised, copies will be mailed to you within sixty (60) days of making the change.

If you have any questions or complaints, or if you do not want to provide your consent to your dentist, to use your protected health information for purposes of payment and/or health care operations, please submit a letter of denial to provide consent to our office.

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of Wai'alae Dental Care's Notice of Privacy Practices for myself /
(Name of Patient or Parent/Legal Guardian)

_____.
If patient is under 18, name of patient

_____
Please Print Patient or Parent/Legal Guardian Name

_____
Patient or Parent/ Legal Guardian Signature Date

For Office Use Only

☐ Individual has signed the written Acknowledgement of Receipt of our Notice of Privacy Practices.

We attempted to obtain written Acknowledgement of Receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign.
☐ Communication barrier prohibited obtaining the acknowledgement.
☐ An emergency situation prevented us from obtaining acknowledgement.
☐ Other (please specify):_____

Dental Office Signature:_____ Date:_____