WAILUKU DENTAL
GROUP, INC.

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, INC.

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 treatment			Stomach Ulcer		
Heart Attack - **When?**			Leukemia			AIDS or HIV Infection		
Artificial Valves - **When?**			Undergoing 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, INC.

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 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, INC.

DENTAL HISTORY

Reason for visit:_____

When was your last dental visit?_____ Describe what was done then:_____

What texture toothbrush do you use? ☐ Soft ☐ Med ☐ Hard Do you use dental floss? Yes No How often?_____

	YES	NO		YES	NO
Do your gums bleed while brushing?	☐	☐	Have you had any head, neck or jaw injuries?	☐	☐
Do your gums bleed when flossing?	☐	☐	Do you have frequent headaches?	☐	☐
Do you feel pain to any of your teeth when brushing or flossing them?	☐	☐	Do you clench or grind your teeth while awake or asleep?	☐	☐
Are your teeth sensitive to hot, cold sweet or sour foods or liquids?	☐	☐	Do you bite your lips or cheeks frequently?	☐	☐
Have you noticed any loosening of your teeth?	☐	☐	Have you ever had:		
Does food tend to become caught between your teeth?	☐	☐	a. Orthodontic treatment (braces)	☐	☐
Do you have any sores or lumps in or Near your mouth?	☐	☐	b. Oral surgery?	☐	☐
Have you ever experienced any of the following problems in your jaw?			c. Gum treatment?	☐	☐
a. Clicking?	☐	☐	d. Your teeth ground or bite adjusted?	☐	☐
b. Pain (joint, ear, side of face)?	☐	☐	e, Worn a bite plane or other appliance?	☐	☐
c. Difficulty in opening or closing?	☐	☐	Do you have any pain in or around your ears?	☐	☐
d. Difficulty in chewing?	☐	☐	Have you lost any teeth?	☐	☐
Have you experienced any complications with extractions?	☐	☐	If yes why?_____		
Describe if yes:_____			Have you replaced any missing teeth?	☐	☐
Do you now have or have you ever had any of the following habits?			With: ☐ Bridge ☐ Partial ☐ Denture ☐ Implants		
			Date of Replacement_____		
			Have you ever had an upsetting experience in a dental office?	☐	☐
			Describe if yes:_____		
			Do you smoke?	☐	☐
			How much and how often?_____		
☐ Thumb or finger sucking			Is there anything about having dental treatment that bothers you?	☐	☐
☐ Chewing on your cheek ☐ Tongue ☐ Lips or ☐ Fingers ☐ Pencils/Pens			Describe if yes:_____		
			Do you have a concern about mouth odor?	☐	☐
Do you like the way your teeth look?	☐	☐	Are you happy with the color of your teeth?	☐	☐
Would you like your teeth to be whiter ?	☐	☐	Would you like your teeth to be straighter?	☐	☐
Would you like your teeth to be longer?	☐	☐	Do you like the shape of your teeth?	☐	☐
Do you have spaces between your teeth that you would like closed?				☐	☐
Do you have missing teeth that you would like to replace?				☐	☐
Do you have old silver fillings that you would like to replace with tooth-colored fillings?				☐	☐
If you could change anything about your smile, would you?				☐	☐

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

WAILUKU DENTAL
GROUP, INC.

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, INC.

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: Cindy Ishimoto 808-244-8808

WAILUKU DENTAL
GROUP, INC.

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, INC.

FINANCIAL GUIDELINES

Our aim is to provide each patient with the finest dental care in a professional environment, which inspires trust and confidence. Our dental office is a business that must be managed efficiently if we are to continue serving our community with quality comprehensive dentistry. Our fees are fair and reflect the care and expertise with which we treat each patient.

To keep our fees from rising considerably and to minimize the expenses of billing and bookkeeping, we offer patients payment options. **We ask that all accounts be paid at the time services are rendered unless other arrangements have been made with the financial office.**

- All fees less than $300 will be due and payable at the time of treatment. We accept cash, check, or credit card. For fees in excess of $300, payment options are available through our financial department.
- If a statement becomes necessary, and is past due a 1.5% per month finance charge will be assessed on the unpaid balance.
- We are a participating provider of HDS & Delta Dental. Patients with these types of insurance need only pay their patient share or co-pay and any non-covered services. Payment for services is expected using the above choices.
- All other insurance companies will be processed through our office on a company by company basis. All services will be paid to this office using the above choices.

All patients with insurance are fortunate, as it will help offset their investment. We are happy to assist you in maximizing your insurance benefits without compromising our standard of care for you.

PAYMENT METHODS

- Cash: This includes money orders, personal checks and cashier checks
- Bank Cards: Cards accepted include Master Card, Visa, Discover and American Express.
- CareCredit: If you need extended payments we have an option, which is excellent. CareCredit is a line of credit for dentistry only, which allows you to pay as little as 3% per month. The initial charge amount will be extended a 90-day interest free period. It is possible that with your credit line we might be able to secure for you a 6-months or even a 1-year interest free period. The application is processed in our office and the information stays in the office. Once approved we can process your balance in full immediately. You will then make your monthly payments to CareCredit.
- Payments: Options are available and we will be happy to discuss these with you. In advance of treatment the patient and the financial department must agree on the financial arrangements. Both parties must sign this agreement in good faith, as this method is in fact a **loan process.**

Our main purpose for having guidelines is to keep our patients informed of their choices and obligations. We want to serve your dental needs and handle the business aspect through a clear understanding by all parties involved. If you have any questions we are always willing to answer them in person or by telephone. Each patient will receive a treatment plan with the fee's and their choices of payment options.

I understand and have read all of the information on this form. I understand and agree that I am responsible for all treatment fees on my account. I understand that if my insurance does not pay for any treatment or pays less than anticipated I am responsible for the entire balance. I am aware that if my account becomes past due I will be assessed a 1.5-%, (18% per annum) finance charge on the total balance.

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