PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form.

Patient name: _____ Date of birth: _____Sex:____

Home address: _____

Phone no: _____

E-mail:_____

Emergency contact name and phone no.:_____

Referred to us by: _____

Confidential Health History Form

Today's date: _____

Patient Name: _____ Date of Birth: _____

Circle appropriate answer (leave blank if you do not understand the question)

1. Is your general health good? Yes/NO
2. Has there been a change in your health within the last year? Yes/ No
3. Have you gone to the hospital or emergency room or had a serious illness in the last 3 yrs.? Yes/No
4. Are you being treated by a physician now? Yes/NO
5. Have you had problems with prior dental treatment? Yes/No
6. Are you in pain now? Yes/No

Have you experienced any of the following?

Chest pain	Blood in stool	Frequent vomiting
Fainting spell	Diarrhea or constipation	Jaundice
Recent significant weight loss	Frequent urination	Dry mouth
Fever	Difficulty urinating	Excessive thirst
Night sweats	Ringing in ears	Difficulty swallowing
Persistent cough	Headache	Swollen ankles
Coughing up blood	Dizziness	Joint pain or stiffness
Bleeding problems	Blurred vision	Shortness of breath
Blood in urine	Bruise easily	Sinus problems

Are you allergic to or have you had a reaction to any of the following?

Aspirin	Valium	Tetracycline
Darvon	Demerol	Vicodin
Codeine	Penicillin	Percodan
Latex	Food	Nitrous oxide
Erythromycin	Metal	Others _____

Have you had or do you have any of the following?

Heart disease	family history of heart disease	Heart attack
artificial joint	Stomach problems	Ulcers
Heart murmur	Rheumatic fever	Skin disease
Hardening of arteries	seizures	High blood pressure
Cosmetic surgery	surgeries	hospitalization
diabetes	Family history of diabetes	Tumors or cancer
chemotherapy	radiation	arthritis
rheumatism	Emphysema or other lung disease	hepatitis
Sexual transmitted disease	herpes	Canker or cold sores
anemia	Liver disease	Eye disease
Transplant	Tuberculosis	AIDS/HIV
Depression	Treatment of emotional condition	

Are you taking or have you taken any of the following in the last three months?

Recreational drugs	Supplements
Tobacco in any form	Weight loss medications
Antibiotics	Bisphosphonate (Fosamax)
Over the counter medicine	Aspirin

Please list all medications you are currently taking:

Women only:

Are you pregnant or could be pregnant?	Are you taking birth control pills?
If YES, what month?	
Are you nursing?	

All Patients:

Do you have or have you had any other disease or medical problems NOT listed on this form?

Is there any issue or condition that you would like to discuss with the dentist in private?

The practice of dentistry involves treating the whole person. If the dentist determines that there may be potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (parent or guardian)	**Date**	**Signature of Dentist**

Dental Health History Form

Today's date_____

Patient Name: _____Preferred Name: _____ Date of Birth_____

What are you goals in coming to our practice today? _____

What is important to you in a dentist or dental practice? _____

What has been your experience with the dentist in the past? _____

Date of last X-rays and exam_____ Date of last hygiene care appointment _____

Former Dentist_____ Phone_____

Address: Street: _____City _____ ST_____ Zip_____

If you left your previous dentist, what are the reasons? _____

Are you experiencing any pain now? YES/NO (circle one)

If yes, please describe _____

Have you ever been pre-medicated for dental treatment? YES/NO (circle one)

If yes, would you be comfortable sharing why? _____

Would you like to discuss this concern with the doctor to learn about your relaxation options? YES/NO (circle one)

Have you ever had orthodontic treatment? YES/NO (circle one) If yes, when? _____

Have you ever had periodontal (gum tissue) treatment; such as deep cleaning, root planning, or periodontal surgery?

YES/NO (circle one) If yes, when? _____

Have you whitened your teeth in the past? YES/NO (circle one) If yes, what method? _____

What concerns do you currently have with your oral health or smile? (Circle all that apply)

Jaw joint pain/ Clenching or grinding of teeth/ Discolored teeth/ Crowding or crooked teeth/ Missing teeth/ Loose teeth/ Tooth shape or size/ unhappy with appearance of teeth/ Overbite/ Under bite/ Old fillings (gold or silver)/ Old crowns/ Speech problems/ Too much gum tissue when I smile/ Tooth sensitivity to hot/cold or anything else/ Food gets caught between teeth/ Difficulty chewing/ Bad breath Other_____

Are you interested in learning more about the following? (Circle all that apply)

Teeth whitening/ Orthodontic treatment/ Veneers/ Tooth-colored fillings/ Dental implants/ How to prevent periodontal disease/ At-home hygiene care/ periodontal treatment during pregnancy/ Oral hygiene care for infants and toddlers

Other_____

Patient Responsibilities: We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of preforming any treatment with our practice. We accept the following forms of payment: Credit Card, cash, Care Credit. *Please note: If you elect to apply for third-party financing, administered through our practice, we require by law to provide you with a Credit for Dental Services Notice.

Dental Benefit Plan: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payment received are based on the contract negotiated between you and your employer and the plan. We are happy to help our patients with dental benefit plan to understand and maximize their coverage.

Our practice IS/IS NOT (circle one) a contracted provider with your dental benefit plan.

If we are a contracted provider with your plan you are responsible only for your portion of the approved fees as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less from the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

If we are not a contracted provider with your dental benefit plan it is the patients responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you ae responsible and will be billed fo r any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at time of services.

Scheduling of appointments: We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on time. Because of this courtesy, when a patient cancels on appointment, it impacts the overall quality of services we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule on appointment. With less than 48-hours' notice, a fee of $25 or a deposit to reserve the appointment time again, may be required. To serve all our patients' in a timely manner we may need to reschedule an appointment if a patient is 15 minutes late or more arriving to our office.

Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. However, you may consent to receive email from us regarding your treatment. We will use minimum necessary amount of protected health information in communication. Our first email to you will verify the email address you provide.

I consent and accept the risk in receiving information via email. I understand I can withdraw my consent at any time. My email address is _____ (yes/no)

I consent only to receiving appointment reminders via email or text. I understand I can withdraw my consent at any time. My email address is _____ (yes/no)

If I do not consent to receiving any information via email, I understand that I can change my mind and provide consent letter later.

Authorizations: I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. _____ (initial)

I have read the above and agree to the financial and scheduling terms. _____ (initial)

I authorize the release of information's necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. YES/NO (circle one) _____ (initial)

I hereby acknowledge that a copy of this practices notice of privacy practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this notice. _____ (initial)

I hereby acknowledge that a copy of this practice's Dental Material Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. _____ (initial)

Signature _____ Date_____

Naina Bhoot DDS

Honolulu Dental

HEALTH INFORMATION PRIVACY ACT
CONSENT TO RELEASE
VERBAL OR WRITTEN INFORMATION

The state of California mandates that medical/dental information may be shared only with the patient or the patient's representative. In accordance with this law, every employee of above listed group is required to sign a confidentiality statement on an annual basis, indicating they will keep the medical information of every patient in the strictest confidence. At our medical/dental office, including physician/s and employees are compliant with the Health Insurance Portability and Accountability Act (HIPAA) privacy rule, which protects the privacy of individually identifiable health information.

Adhering to the confidentiality policy is difficult when family members (spouse, children, and siblings) inquire about a patient's medical/dental care. The staff and/ or physicians cannot release medical information without permission from the patient or the patient's legal representative.

If you wish to give permission for staff and / or physicians to verbally release general medical/dental information to family members, list the name/s and relationship of those individuals in the space provided below.

General medical/dental information excludes the discussion of psychiatric services; drug and alcohol counseling; sexually transmitted diseases; HIV testing; pregnancy or termination of pregnancy.

If you do not wish to give permission of general medical information to be released verbally to family members, check here ☐ and sign below.

Name	Date of Birth	Relationship

I authorize that the above individual/s may have access to information regarding my general medical conditions. I will notify above listed physician group, if I wish to add or delete individuals who may have access to my medical information.

Patient Name and Signature _____ Date _____ Witnessed by _____