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Patient Information

Name: _____ **Preferred Name:**_____

Date of Birth: _____/_____/_____ **[ ]** Male **[ ]** Female **[ ]** Other

Home Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone #: _____ **Email:** _____

How Did You Hear About Us?

[ ] Google **[ ]** Yelp **[ ]** Family/Friend **[ ]**Facebook **[ ]** Dentist **[ ]** Physician **[ ]** Walk in, Drive by

Please include the name of your referral source so we may thank them! _____

Contact Information/Responsible Party

Name: _____ **SSN:** _____

Relationship to patient: [ ] Parent **[ ]** Step-Parent **[ ]** Legal Guardian **[ ]** Foster Parent

Date of Birth: _____/_____/_____ **[ ]** Male **[ ]** Female **[ ]** Other

Address (if different from above): _____

Does this person hold insurance for the patient? [ ] Yes **[ ]** No

Insurance Carrier: _____ **Subscriber ID:** _____

Additional Responsible Party

Name: _____ **SSN:** _____

Relationship to patient: [ ] Parent **[ ]** Step-Parent **[ ]** Legal Guardian **[ ]** Foster Parent

Date of Birth: _____/_____/_____ **[ ]** Male **[ ]** Female **[ ]** Other

Address (if different from above): _____

Does this person hold insurance for the patient? [ ] Yes **[ ]** No

Insurance Carrier: _____ **Subscriber ID:** _____

Is your child currently enrolled in QUEST through the State of Hawai'i? [ ] Yes **[ ]** No

If yes, what is their subscriber ID: _____

REQUEST AND CONSENT FOR PEDIATRIC DENTAL TREATMENT

Please read this form carefully! If you do not understand something to your satisfaction, please ask questions. We will be pleased to explain it to you!

Dental History

Is this your child's first dental visit? [ ] Yes **[ ]** No **Date of last visit: _____**

Reason for today's dental visit? _____

Does your child have any of the following habits?

[ ] Thumb/finger sucking **[ ]** Pacifier **[ ]** Bottle/Nursing habits **[ ]** Evening Bottle/Nursing

[ ] Teeth Grinding/Bruxism

Does your child brush & floss his/her own teeth? [ ] Yes **[ ]** No

When does your child brush & floss? [ ] A.M. **[ ]** P.M. **[ ]** After Meals

Has your child used fluoride in any of the following forms? (Check all that apply)

[ ] Fluoride tablets **[ ]** Fluoride Toothpaste **[ ]** Fluoride Varnish (dental visits)

Medical History

Child's Primary Care Physician: _____ Ph Number: _____

Does your child have any of the following medical conditions? (Please circle)

ADD/ADHD	Disability/Special Needs
HIV+/AIDS	Eating Disorder
Allergies	Hearing/Visual Impairment
Asthma	Hepatitis
Autism	Hospital Stays
Blood Disorders	Immune Disorders
Bone/Muscular Disorders	Kidney/Liver Conditions
Cancer	Tuberculosis
Congenital Birth Defects	Heart Disease/Murmur
Seizures/Epilepsy	Diabetes
Depression/Anxiety	High/Low Blood Pressure

Other: _____

Has your child ever taken antibiotics as a pre-med before a dental visit? [ ] Yes **[ ]** No

Discuss any serious medical conditions: _____

_____

List all medications your child is currently taking: _____

_____

List all allergies (drugs, latex, etc): _____

_____

Accompanying Your Child

A parent or legal guardian must be present during all restorative treatment appointments unless the authorized person is listed below or a signed letter is provided.
Please list any person(s) other than legal parents/guardians, who are authorized to accompany your child and are authorized to make medical decisions on the legal guardians behalf.

Name: _____ **Relation:**_____

Name: _____ **Relation:**_____

(authorized person(s) must present ID upon arrival)

REQUEST AND CONSENT FOR PEDIATRIC DENTAL TREATMENT

Please read this form carefully! If you do not understand something to your satisfaction, please ask questions. We will be pleased to explain it to you!

- I request and authorize the treatment and procedures (i.e. exam, x-ray and/ or cleaning, etc.) outlined on the PLAN OF TREATMENT for my child.
- I further request and authorize the taking of oral dental x-ray and the use of such anesthetics as may be considered necessary to treat the patient's dental problem(s).
- The usual and most frequent risk or complication occurring from the planned treatment and procedures also have been explained to me. These risks include, but are not limited to the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of the temporomandibular joint disorder, temporary or permanent numbness, and allergic reaction.
- I understand that during the course of the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on the patient's PLAN OF CARE and that I will be consulted prior to initiation of treatment procedures not listed. I am aware that the practice of dentistry is not an exact science and acknowledges that no guarantees have been made to me concerning the results of the dental treatment that the patient receives in Dr. Lee's office or (at the hospital in some cases).
- I understand that treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms of age appropriate for their age. Behavior will be guided using praise, explanation and demonstration of procedures and instruments, using variable voice tone and loudness.
- I understand that should the patient become uncooperative during dental procedures either movement of head, arms and/ or legs, dental treatment cannot be safely provided. During such disruptive behavior, it may be necessary for the assistant(s) and/ or parent to hold the patient's hands, stabilize and head and/ or control leg movement.
- All of my questions have been answered to my satisfaction and consent to treatment and procedures prescribed for the patient on the PLAN OF CARE.
- I understand that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.
- I confirm that I have read and understand this form or it was read to me, and that all blanks were filled in and all inapplicable paragraphs, if any, were stricken before I sign below.

_____ _____

Parent/ Guardian Signature Date

FINANCIAL POLICY

Assignment and Release

I, the undersigned, have insurance with _____, and assign directly Hawaii Pediatric Dentistry all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Patient Agreement and Financial Policy

I hereby agree to be responsible for the costs of care provided by Hawaii Pediatric Dentistry and/or the dental team for myself or my dependent(s). These include any deductibles and amounts not covered by insurance. **I also understand that it is my responsibility to be aware of any limitations, and benefits of my insurance policy.** Payment to this office is my responsibility and I am aware that if the insurance company does not reimburse the doctor, I am responsible for the total amount(s).

- **I understand that because appointments are not double-booked, I must provide notice of cancellation at least 48 hours prior to my scheduled appointment time**. ***For appointments scheduled with the doctor, I will be required to make a <u>reservation fee of $100</u> prior to scheduling the appointment, which will be applied to my out-of-pocket expense for the scheduled visit. This reservation fee is non-refundable. If I do not show up for my appointment or I do not give adequate notice if I am unable to keep my appointment, the reservation fee will be forfeited.***

We make every effort to schedule appointments that are most convenient for you and that fit your personal schedule. Because we do not schedule several patients at the same time, all appointments are reserved exclusively for you. In return, we ask that you make every effort not to change your reserved dental appointment.

I understand that for any treatment payment in full is due at the time of service. I understand that after 60 days, any unpaid balance will incur a $15 billing fee. I understand that failure to pay amounts due to this office will result in my account being placed with a collection agency. In the event that my account is further referred to an attorney, I agree to pay all collection and attorney fees.

Minor/Child Consent

I, being the parent or legal guardian of _____, do here, by request and authorize the dental staff to perform necessary services for my child, including but not limited to radiographs (x-rays) and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered. I also understand that the parent or guardian who brings my child in for treatment will be responsible for payment. A receipt will be provided so I may seek reimbursement.

Date: _____ **Signature:** _____

Signature of patient/parent/legal guardian

Hawaii Pediatric Dentistry

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of Hawaii Pediatric Dentistry. I hereby authorize, as indicated by my signature below, Hawaii Pediatric Dentistry to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____

Print Name Address

_____ _____

Signature Date

Please check your preferred means of communication:

□ You may contact me at my home telephone number _____

□ You may contact me on my mobile telephone number _____

□ You may contact me on my work telephone number _____

□ You may send me an unencrypted email/text message at: _____

□ Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____ Date Added / Removed:_____

2. _____ Date Added / Removed: _____

3. _____ Date Added / Removed: _____

4._____ Date Added / Removed: _____

For Office Use Only:

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 barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining the acknowledgement

□ Other (Please Specify) _____

Staff Person Initials _____