HAWAII FAMILY DENTAL

PATIENT INFORMATION FORM

This information is being provided to you to help you understand Hawaii Family Dental Center's (HFDC) outlook toward providing our patients with quality dental care. Your dentist wants to be certain that you are provided with all of the information you need to know before your treatment begins. This is HFDC's way of insuring that you, as an HFDC patient, are confident and well informed regarding the dental care you receive. **PLEASE ASK QUESTIONS!** The HFDC staff will be happy to answer any questions you have concerning your dental care.

EXPLANATION OF THE EXAMINATION:

1. Medical and dental history, oral examination(s), x-rays, and other diagnostic aids obtained from you by your dentist will determine the recommended treatment for you. Diagnostic aids are services such as photographs or study models of your teeth and/or surrounding areas of your mouth, and pulp vitality tests that reveal the condition of the inside of your teeth.
2. The condition of your bones and tissues cannot be seen by the naked eye. Therefore, your dentist will recommend the number of x-rays necessary to reach an accurate diagnosis. During exposure to x-rays, the American Dental Association (ADA) requires that precautionary measures are adhered to. HFDC remains in compliance with the requirements at all times. Please speak with your dentist if you have any concerns regarding x-rays.
3. Any information you may have regarding your individual necessities or preferences are welcome by your dentist and staff. Your signature is required on the treatment plan. You are responsible to be certain that when you sign the treatment plan, you understand all of the information in it, the information in it is complete, and that it satisfies all of your individual needs. Your dentist will take into consideration the wants and needs you have as a patient. Please be sure to communicate your preferences to your dentist.

PROPOSED TREATMENT:

The dentist will recommend a treatment plan and a dental cleaning based on the condition of your mouth at the time of the examination. The dentist will explain to you the nature, complications, and alternatives to the proposed treatment. The dentist will also discuss with you the estimated time it will take to complete the treatment.

ALTERNATIVE TREATMENT:

There are many ways to treat a patient's dental condition. The dentist will choose the treatment that best fits your needs. There may be other options of treating a particular dental condition. Your dentist will explain those options to you.

RISKS OF RECOMMENDED TREATMENT:

There is no dental treatment that is free of risk. Your dentist will take the reasonable and steps necessary to limit any complications during treatment. There are some complications that tend to occur with some regularity. When you have questions about these complications, or about any other complications you have heard or thought about, please ask our staff. Your dentist believes that treatment is more successful when the patient knows as much as possible about it. Only you will be able to provide the necessary information for your dentist and ask the best questions that pertain to the treatment plan for you.

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FINANCIAL INFORMATION

1. A financial consultation is given before the start of any and all treatment; and after your initial examination. All charges that are your responsibility are due at the time of service. If you cannot make payment, please notify the Patient Service Representative. All outstanding account balances are the responsibility of the account guarantor (the individual financially responsible for the account). When an account accumulates a substantial balance, dental services may be discontinued until the balance is paid.
2. We will do our best to give you the best estimate for your treatment. We can only ESTIMATE your insurance coverage -- the actual payment by your insurance company may be more or less.
3. For those patients who have a private insurance carrier for which HFDC is not participating, HFDC is happy to complete the necessary claim forms at no charge. It is the patient's responsibility to file the claim form with their insurance carrier.
4. A $100.00 fee may be charged when an appointment with a General Dentist and/or Hygienist is broken or canceled less than 48 hours prior to the appointment time. A $100.00 fee may be charged when an appointment with a Specialist is broken or canceled less than 5 business days prior to the appointment time. If unable to make your scheduled appointment, please let us know as soon as possible so we may release your reserved appointment time for use by another patient and to reschedule your appointment.
5. A handling fee of $30.00 will be charged for checks returned from the bank due to insufficient funds.
6. A late payment charge of 1.5% per month or 18% annual percentage rate (APR) will be charged for a delinquent balance over 60 days. Accounts that are 90 days delinquent and beyond, may be forwarded to a collection agency.

The undersigned certifies that he/she understands the foregoing, and is the patient, or the patient's parent or legal guardian, and is duly authorized to execute and accept the terms explained in this document.

_____ _____

Patient Date

_____

Signature

Because the patient is a minor of _____ years, the above consent is given on the patient's behalf by:

_____ _____

Parent or Guardian's Name (print) Date

_____

Parent or Guardian's Signature

HAWAII FAMILY DENTAL

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.

Hawaii Family Dental Centers (HFDC) 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 HFDC.

Use or Disclosure of Your Health Information

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

For Payment:
HFDC 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 your dentist, 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:
HFDC 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:
HFDC 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:
HFDC may use and disclose information about you as required by law. For example, HFDC 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.

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 your dentist 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 your dentist.

Complaints

You may submit complaints to HFDC, your 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 HFDC

HFDC 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 your 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.

HFDC 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 HFDC, 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:

Privacy Officer
Hawaii Dental Group, Inc.
dba, Hawaii Family Dental Centers
Seven Waterfront Plaza, Suite 220
500 Ala Moana Blvd.
Honolulu, Hawaii 96813
Phone: (808) 523-3103
Toll Free: (808) 888-542-4445

HAWAII FAMILY DENTAL

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of this dental office's
(Name of patient)
Notice of Privacy Practices.

_____
Print Name

_____
Signature of Patient or Personal Representative

_____
Date

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 barrier prohibited obtaining the acknowledgement.

☐ An emergency situation prevented us from obtaining acknowledgement.

☐ Other (please specify).

_____

_____

_____

Dental Center Signature:_____ Date:_____

HAWAII FAMILY DENTAL

Patient Personal Information

Title		Nickname		Birth Date	Age
Last, First				Marital Status	Sex
Address				Home #	Work #
				Cell #	Drive Lic
City, State, Zip				Student	SSN
Email				School Name	
				Referral Type	

Person responsible/guarantor for paying bills

Title		Nickname		Birth Date	Age
Last, First				Marital Status	Sex
Address				Home #	Work #
				Cell #	Drive Lic
City, State, Zip				SSN	
Email					

Do you have Primary Dental Insurance? __ Yes __ No				Do you have Secondary Dental Insurance? __ Yes __ No			
Group No/Name				Group No/Name			
Insurance Name				Insurance Name			
Phone #				Phone #			
Employer Name				Employer Name			
Subscriber Last, First				Subscriber Last, First			
Subscriber Address				Subscriber Address			
City, State, Zip				City, State, Zip			
Relationship to Patient		Birth Date		Relationship to Patient		Birth Date	
Subscriber ID				Subscriber ID			

Patient Medical Information

Allergic to

- ☐ Y ☐ N Any Drugs or Medications
- ☐ Y ☐ N Latex Rubber
- ☐ Y ☐ N Local or Topical Anesthetics
- ☐ Y ☐ N Other Allergies

Medical Alerts

- ☐ Y ☐ N Artificial Heart Valve
- ☐ Y ☐ N Artificial Joints (Hip/Knee)
- ☐ Y ☐ N Asthma
- ☐ Y ☐ N Autism or ADHA
- ☐ Y ☐ N Bleed or Bruise Easily
- ☐ Y ☐ N Blood Pressure Problems
- ☐ Y ☐ N Bone Disease / Osteoporosis
- ☐ Y ☐ N Chest Pain
- ☐ Y ☐ N Congenital Heart Lesion
- ☐ Y ☐ N Cancer / Cancer Treatment
- ☐ Y ☐ N Diabetes/Blood Sugar Problems
- ☐ Y ☐ N Drug Addiction
- ☐ Y ☐ N Excessive Thirst / Dry Mouth
- ☐ Y ☐ N Epilepsy or Seizures
- ☐ Y ☐ N Fainting / Dizziness / Vertigo
- ☐ Y ☐ N Heart Murmur
- ☐ Y ☐ N Heart Trouble
- ☐ Y ☐ N Heart Pacemaker
- ☐ Y ☐ N Heart Surgery
- ☐ Y ☐ N Hepatitis
- ☐ Y ☐ N HIV / AIDS
- ☐ Y ☐ N Kidney Trouble / Dialysis
- ☐ Y ☐ N Lung Disease / Emphysema
- ☐ Y ☐ N Liver Disease/Yellow Jaundice
- ☐ Y ☐ N Nervousness/Psychiatric Care
- ☐ Y ☐ N Stroke
- ☐ Y ☐ N Sinus Trouble
- ☐ Y ☐ N Shortness of Breath
- ☐ Y ☐ N Tuberculosis
- ☐ Y ☐ N Thyroid Disease

DENTIST ALERTS (Dr.)

- ☐ Y ☐ N Premed for Dental Tx
- ☐ Y ☐ N Special Precautions

Dental Questionnaire

Primary reason for this dental appointment? _____

Do you have a specific dental problem?

If yes, please describe and what would you like done?

When was your last dental exam and cleaning?

Would you describe your present dental health as good?

Do you feel anxious about having dental treatment?

Have you ever had a bad experience in a dental office?

If yes, please describe:

Do you brush and floss your teeth daily?

Have you ever been diagnosed or treated for gum disease?

Name of previous dentist:

If you could rate your smile from 1-10, what would it be?

Would you like to improve your smile?

If yes, how would you like to improve your smile?

DENTIST'S NOTES

Notes:

Medical Questionnaire

Medical Physician's name?

Are you currently under care of a Physician ?

If Yes, what is the condition(s) being treated ?

Have you ever had a serious illness, operation, or been hospitalized ?

If Yes, What - Why - When ?

Are you currently taking any medications ?

If Yes, please list the medications:

List additional medications or OTC medications or supplements you routinely take:

Are you allergic to any medications?

If yes, please list the medications:

List additional drug allergies:

List other allergies:

Tobacco, alcohol, or street drug use?

If Yes - what, how much, how often?

Additional Comments

Any Disease, Condition or Disorder not Listed Above? List here:

WOMEN ONLY

Are you pregnant?

If Yes, when is your due date ?

Are you currently nursing?	
Emergency Contact Info	
Emergency Contact #1 - Name/Phone#	
Emergency Contact #2 - Name/Phone#	
DENTIST'S NOTES	
Vital signs #1 (BP/HR/Date/Time):	
Vital signs #2 (BP/HR/Date/Time):	
Vital signs #3 (BP/HR/Date/Time):	
Vital signs #4 (BP/HR/Date/Time):	
Medical consult requested (MIR)?	☐
Medical consult (MIR) received back?	☐
Dentist's medical interview notes:	

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature **Date**