HAWAII FAMILY DENTAL

Patient Information Form

Patient name _____

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. 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 be 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 welcomed by your dentist and staff. 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 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. (Your signature is required on the treatment plan, you understand all of the information on it, the information is complete, and that it satisfies all of your individual needs.)

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.

Risk of Recommended Treatment
There is no dental treatment that is free of risk. Your dentist will take the reasonable steps necessary to limit any. Will be able to provide the necessary information to your dentist and ask the best question that pertain to the treatment plan for you.

I acknowledge and understand that, although very rare, complications with injected local anesthesia may include swelling, bleeding, infection, and discomfort at the injection site. Prolonged numbness

and tingling sensation in the oral cavity, usually temporary, but can be permanent. Muscle cramps or spasms, joint pain, allergic reactions, nausea and vomiting, rapid or irregular heartbeat, biting of cheeks, lip, and tongue after treatment resulting in swelling and discomfort may also occur.

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 services. If you cannot make payment, please notify the Patient Concierge. 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 coompany may be more or less. You are responsible for any additional balance due. Any credit due will be applied to your account.

3. For those patients who have a private insurance carrier for which HFDC is not participating, HFDC is happy to complete the complete necessary claim forms at no charge. It is the patient's responsibility to file the claim form with their insurance carrier.

4. You will continue to enjoy the ability to reserve pre-scheduled hygiene appointments without a reservation fee as long as you give us at least 48 hours notice if you cannot keep your appointment. Out of courtesy to the long list of patients waiting to see your dentist and hygienist, if you do not notify us within 48 hours then a $100 deposit will be required to reserve an appointment. For treatment appointments with dentists, 50% of your out of pocket fee will be collected at the time of scheduling.

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.

7. Hawaii Family Dental sends all statements via an email link to download. If you do not wish to receive email notifications of statements**,** you must opt out by checking the box below. I agree to receive my statement via email and am opting out of electronic statements.

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 Signature: _____

Patient Name: _____

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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 treatmen 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 *W*orkers Compensation

<u>Your Health Information Rights</u>

You have the right to:

- Request a restriction on certain uses or disclosures of your protected health information, how*ever*, 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,

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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

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Acknowledgement of Receipt of Notice of Privacy Practice

I _____, have received a copy of this dental office'

(Name of Patient)

Notice of Privacy Practice

_____

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: _____

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AUTHORIZATION FORM

This authorization regarding the use and/or disclosure of your protected health information is required under federal law. The protected health information that will be used or disclosed is:

_____

_____

The name, or other specific identification, of the person(s), or class of person(s), authorized to make the requested use or disclosure is:

The name or other specific identification, of the person(s), or class of person(s), to whom Hawaii Family Dental Centers (HFDC) may make the requested use or disclosure is:

This authorization will expire on _____ [date]. You may revoke this authorization in writing by contacting the following party:

Attn: HIPAA Privacy Officer
Seven Waterfront Plaza
• 500 Ala Moana Blvd., Suite 220
Honolulu, HI 96813

However, you may not revoke in the event that HFDC has taken action in reliance on such authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Please note that the information that is used or disclosed pursuant to this authorization may be subject to re-disclosure by HFDC and would therefore no longer be protected under the terms of the federal privacy rule.

I _____, hereby certify that I have read the provisions set forth in this authorization. I understand and agree to its terms.

This authorization will be maintained by HFDC for a period of six (6) years.

_____
Print Patient Name

Patient Signature or Personal Representative _____ Date: _____

For HFDC use only

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Date Received: _____ Signature of Recipient:_____

Patient Personal Information							
Title		Nickname		Birthdate		Age	
Last, First				Marital Status		Sex	
Address				Home #		Work #	
				Cell #		Driver Lic	
City,State, Zip				Student		SSN	
Email				School Name			
				Referral Type			
Person responsible/guarantor for paying bills							
Title		Nickname		Birthdate		Age	
Last, First Name				Marital Status		Sex	
Address				Home #		Work #	
				Cell #		Driver Lic	
City,State, Zip				SSN			
Email							
Do you have Primary Dental Insurance? ☐ Yes ☐ No				**Do you have Secondary 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			

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Patient Medical Information

Allergic to					
☐Y ☐N	Any Drug or Medications	☐Y ☐N	Blood Pressure Problem	☐Y ☐N	Heart Trouble
☐Y ☐N	Latex Rubber	☐Y ☐N	Bone Disease/Osteoporosis	☐Y ☐N	Heart pacemaker
☐Y ☐N	Local or Topical Anesthetics	☐Y ☐N	Chest Pain	☐Y ☐N	Heart Surgery
☐Y ☐N	Other Allergies	☐Y ☐N	Congenital Heart Lesion	☐Y ☐N	Hepatitis
Medical Alerts		☐Y ☐N	Cancer/Cancer Treatment	☐Y ☐N	HIV/AIDS
☐Y ☐N	Artificial Heart Valve	☐Y ☐N	Diabetes/Blood Sugar Problem	☐Y ☐N	Kidney Trouble/Dialysis
☐Y ☐N	Artificial Joint (Hip/Knee)	☐Y ☐N	Drug Addiction	☐Y ☐N	Lung Disease/Emphysema
☐Y ☐N	Asthma	☐Y ☐N	Excessive Thirst/Dry Mouth	☐Y ☐N	Liver Disease/Yellow Jaundice
☐Y ☐N	Autism or ADHA	☐Y ☐N	Fainting/Dizziness/Vertigo	☐Y ☐N	Nervousness/Psychiatric Care
☐Y ☐N	Bleed or Bruise Easily	☐Y ☐N	Heart Murmur	☐Y ☐N	Stroke
				☐Y ☐N	Sinus Trouble
				☐Y ☐N	Shortness of Breath
Dentist Alerts(Dr.)				☐Y ☐N	Thyroid Disease
☐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?

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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 medication?
If yes, please list the medications:

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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):

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Vital Signs #4 (BP/HR/Date/Time):
Medical consult requested (MIR)
Medical consult (MIR) received back?
Dentist's Medical interview notes:
Covid Patient Disclosures
Do you have a fever or above normal temperature?
Have you experienced shortness of breath or had trouble breathing?
Do you have a dry cough?
Do you have a runny nose?
Have you recently lost or had a reduction in the sense of smell?
Do you have a sore throat?
Have you been in contact with someone who has tested positive for COVID-19?
Have you tested positive for COVID-19?
Have you been tested positive for COVID-19 and are waiting for results?
Have you traveled outside the United States by air or cruise ship in the past 14 days?
Have you traveled outside the United States by bus or train within the past 14 days?

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

_____

Patient/Guardian Signature

Date: