ALOHA DENTAL ASSOCIATES

"We take your smile to heart"

Patient Information

Full Name: _____ Preferred: _____

Address: _____ City: _____ State: _____ Zip:_____

Birthdate: _____ SSN: _____ Marital Status: [ ] Married [ ] Single [ ] Other

Phone # Cell: _____ E-Mail: _____

Occupation: _____ Company: _____

Emergency Contact: Name: _____ Relationship: _____ Phone #: _____

How did you hear about our office? [ ] Yelp [ ] Google [ ] Facebook [ ] Friend: _____ [ ] Other

Dental Insurance Information

Primary Insurance: _____ Subscriber Name: _____ DOB: _____

Group #: _____ Subscriber ID/SSN: _____ Relation to patient: _____

Second Insurance: _____ Subscriber Name: _____ DOB: _____

Group #: _____ Subscriber ID/SSN: _____ Relation to patient: _____

With dental insurance, we strive for you to receive your maximum benefits. While we assist you with billing your insurance company, you are primarily responsible for determining what your insurance will cover.

Financial Policy

- I understand that any services performed without previous financial arrangement must be paid in full at the time service is rendered. *Initials X*_____

- If I do not pay the entire new balance within **60** days of the monthly billing date, a service charge will be added to the account for the current monthly billing periods. There service charge will be a periodic rate of **1.5%** per month (or a minimum charge of **$3.00** for a balance under **$200.00**.) which is an annual percentage rate of **18%** applied to last month's balance. In case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this amount or future outstanding accounts. *Initials X*_____

Authorization

I the undersigned authorize and request the insurance company to pay directly to the dentist or dental group insurance payments otherwise payable by me. 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 to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I have read the above conditions of treatment and payment and agree to their content.

Responsible Party Signature _____ Date _____

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Office Policy

Thank. you for choosing us as your dental care provider. Our office is committed to providing you with the best possible care. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the doctor.

Regarding Payment

Please be prepared to remit payment for services rendered on the day of treatment. **Patient's Initial x_____**
We accept the following forms of payment: Cash, Check, Visa and MasterCard.

If dentures, partial dentures, crown and bridge are to be fabricated by a dental laboratory, a 50% deposit will be required at the time of the first impression. The remaining balance is due at the time the prosthesis is cemented or inserted. **Patient's Initial x_____**

The parent that accompanies the minor child/children to the appointment is responsible for any payment due. For unaccompanied minors, nonemergency treatment will be denied unless charges have been pre-authorized before the appointment date or previous arrangements have been made with the doctor and billing receptionist.

Checks that are returned to our office from your financial institution are subject to a $**25.00** returned check fee. This fee covers the processing fees that are charged to our office. **Patient's Initial x_____**

Families are kept on a single family ledger and account within our office. Unless our front desk staff receives a request from the patient to split family members on to their own accounts, families will remain on a single account with a single family balance which the account guarantor shall be accountable for. **Patient's Initial x_____**

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 60 days, the balance may be transferred to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary for our area. You are responsible for payment regardless of any insurance company arbitrary determination of usual and customary rates.

Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. Most benefits will be verified before your insurance company can be billed.

All insurance co-pays and deductibles must be paid at the time of service. **Patient's Initial x_____**

Regarding Radiographs (X-rays)

Dr. Choy requires each of our patients to be seen every six (6) months for a detailed examination, cleaning and bitewing radiographs (x-rays). We especially insist on children under the age of 18 to follow this 6-month schedule. **Insurance coverage varies and, on occasion, may not cover these services.** If this is a concern to you, please consult with our staff prior to treatment otherwise we will provide you with these services as our standard of care. Any expense not covered by your insurance company will remain your responsibility.

Regarding Missed Appointments

Please note that, unless canceled at least 48 hours in advance, you may be charged for missed appointments at the rate **$50.00** per hour of treatment scheduled or fraction thereof. ***Please call our office as soon as possible if you have to reschedule***.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Thank you for understanding our Office Policy. Please let us know if you have any questions or concerns.

I have read the Office Policy. I understand and agree to this Office Policy.

Signature of Patient or Responsible Party:_____ Date:_____

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Medical History

Current Primary Physician: _____ Office Phone Number: _____
Date of last examination: _____

Please indicate below if you have or ever had:

1. [ ] Hospitalization for illness or injury: _____
2. [ ] Allergic reaction to any of the Following:
   [ ] Antibiotics: _____ [ ] Pain Medications: _____
   [ ] Latex [ ] Fluoride [ ] Sulfa [ ] Metals [ ] Local Anesthetic [ ] Other: _____
3. [ ] Cardiovascular/Heart Concerns:_____ Meds:_____
4. [ ] Artificial/Joint Replacement(s): [ ] Heart Valve [ ] Joint Replacement [ ] Other: _____
5. [ ] Previously needed pre-medications prior to dental treatment
6. [ ] Scarlet Fever [ ] Rheumatic Fever: When: _____
7. [ ] High blood pressure [ ] Low Blood Pressure: Meds:_____
8. [ ] Stroke: (When) _____ Meds:_____
9. [ ] Blood Disorder: _____ [ ] Blood Thinner: _____
10. [ ] Respiratory Concerns: [ ] Asthma [ ] Tuberculosis [ ] Other: _____
11. [ ] Kidney Disease [ ] Liver Disease [ ] Thyroid Disease [ ] Other: _____ 12. [ ] High Cholesterol: (Meds) _____
13. [ ] Viral Infections: [ ] HIV/AIDS [ ] Cold Sores [ ] HPV [ ] Hepatitis (Type) _____ 14. [ ] Sexually Transmitted Infections Please list:_____ 15. [ ] Current or past psychiatric care.
16. [ ] Cancer: (Type) _____ [ ] Chemotherapy [ ] Radiation Therapy
17. [ ] Head or Neck Injuries:
_____
18. [ ] Skin Conditions [ ] Eczema [ ] Rash [ ] Hives [ ] Other:
_____
19. [ ] Sleep Apnea/Snoring. Do you use a device? [ ] Mouth guard [ ] CPAP [ ] None [ ] Other _____

Check any that apply:

[ ] Arthritis [ ] Glaucoma [ ] Emotional Problems [ ] Osteoporosis
[ ] Tumor(s) [ ] Epilepsy/Seizures [ ] Tuberculosis [ ] Diabetes type: _____
[ ] Ulcers [ ] Antidepressants [ ] Alcohol/Drug Dependency [ ] Psychiatric Disorder
[ ] Smoker [ ] Headaches [ ] Fatigued/Exhausted often

Females: [ ] Birth Control_____ [ ] Pregnant: (Weeks) _____ [ ] Prenatal Vitamins
Males: [ ] Prostate Disorder

List any medications not specified above: _____

_____

List any medical conditions you are being any treated for not specified above: _____

_____

Patient Signature:_____ **Date:**_____
Doctor Signature:_____ **Date:**_____

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Dental History

Previous Dentist: _____ Office phone number: _____

Date of last dental visit: _____ Any X-rays taken at that visit: [ ] Yes [ ] No **As your dental office what is the most important thing we can do for you?**

[ ] Preventative [ ] Affordable [ ] Cosmetic [ ] Time [ ] Other: _____

Please indicate below only if it applies to you:

1. [ ] Are you fearful of dental treatment? (Circle) Low 1 2 3 4 5 6 7 8 9 10 High
2. [ ] Have you had an unfavorable dental experience? Why? _____
3. [ ] Difficulties with local anesthetic? (getting numb)
4. [ ] Orthodontic Treatment? How long ago? _____ Do you use a retainer? [ ] Yes [ ] No
5. [ ] Any adult teeth previously removed?
6. [ ] Previously been treated for gum disease?
7. [ ] How often do you; brush _____ X a day floss_____ X a day Do your gums bleed? [ ] Yes [ ] No
8. [ ] Use an electric toothbrush or waterpik
9. [ ] Jaw complications? (Circle) Popping Clicking Locking Pain Difficulty opening
10. [ ] Any cavities within the past 3 years?
11. [ ] Sensitive teeth? (Circle) Hot Cold Sweets Biting
12. [ ] Catch yourself clenching or grinding your teeth? [ ] Yes [ ] No
13. [ ] Currently use a night guard appliance? [ ] Yes [ ] No
14. [ ] Experienced burning sensation in mouth?
15. [ ] Difficulty biting into hard foods? Teeth feel loose without injury.
16. [ ] Food gets caught between teeth frequently?
17. [ ] Have difficulties chewing?
18. [ ] Notice gum recession or notches on your teeth near gum line?
19. [ ] Dislike the appearance of your teeth. (Circle) Discoloration Crooked Spacing Teeth Size/Shape
20. [ ] Have you ever experienced an unpleasant odor or taste in your mouth?

What is your immediate concern for your dental needs?

_____

_____

What would you like to improve about your smile? [ ] Whiten [ ] Straighten [ ] Change size or shape of teeth

[ ] Replace silver fillings with white [ ] Other: _____

Patient Signature:_____ **Date:**_____ **Doctor Signature:**_____ **Date:**_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You may refuse to sign this acknowledgement

I, _____ have received a copy of 'ALOHA DENTAL ASSOCIATES' Notice of Privacy Practices.

_____
Please print name

_____
Signature

_____
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 barriers prohibited obtaining this acknowledgement. ○ An emergency situation prevented us from obtaining this acknowledgement.
- Other (please specify)

_____

This notice describes how health information about you may be used and disclosed and how you can get access to the information. Please review it carefully. The privacy of your health information is important to us.

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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 take effect 4/12/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practice 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 the Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURE OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use 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 service 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, conduction 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 a authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those describe in this Notice.

To you family and friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice.

Persons Involved in Care: We may use or disclose 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 even of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only heal information that is directly relevant to the person's involvement in your healthcare. We will 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.

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, ort 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 of 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 authorize Federal officials health information required for lawful intelligence, counterintelligence, and other national security activated. 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, we will charge you $40 for staff time to locate and copy your health information and postage if you want the copies mailed to you. If you request as 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 the Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list instances in which we or our business associates disclosed your health information for purpose, other that treatment, payment healthcare operations and certain other activated, 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 request.

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.)

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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 of your 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.
Electronic Notice: If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 complaint use 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 Service. 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:___Leah Lee_____

Telephone:___808-254-2339 Fax 866-868-8911__
Email: N/A_____ Address:
970 N. Kalaheo Ave. #A101 Kailua, HI 96734