Patient Registration Form

Date: _____

Patient Information:

First Name	Middle	Last	Prefers to be called
Address		Gender **M F**	Birth date / Age
City	State	Zip Code	
Home No.:	Cell No:	Preferred Email:	

Father's Name:		Mother's Name:	
Birth date	Social Security No.	Birth date	Social Security No.
Employed by		Employed by	
Work No:	Cell No:	Work No:	Cell No:

Who Does The Child Reside With?

☐ Mother ☐ Father ☐ Both ☐ Other:_____

Please Provide Additional Contact Information:

Emergency Contact Person	Phone No:	Relationship
Address	City State Zip Code	

THE BIGGEST COMPLIMENT OUR PATIENTS GIVE US IS THE REFERRAL OF THEIR FAMILY AND FRIENDS…

Who may we thank for referring you?	Are they a patient here?

Other:

☐ Google ☐ Yelp ☐ Facebook ☐ Instagram

☐ Insurance Company ☐ Commercial ☐ Other:_____

PRIMARY DENTAL INSURNACE		***SECONDARY DENTAL INSURANCE***	
Insurance Company Name;		Insurance Company Name:	
Subscriber ID#	Group #	Subscriber ID#	Group #
Insured Name:		Insured Name:	
Birth date:	Insured's Social Security #:	Birth date:	Insured's Social Security #:

NEW PATIENTS ONLY:

Previous Dentist	Date of last dental exam
Address	Phone No

IF THERE IS ANY X-RAYS TAKEN FROM PREVIOUS DENTIST PLEASE PROVIDE OFFICE.

Dental History			
Reason for today's visit:	☐YES	☐NO	Explain:
Has your child complained about any dental problems	☐YES	☐NO	Explain:
Any injuries to mouth - teeth – head	☐YES	☐NO	Explain:
Any mouth habits – thumb sucking, nail biting, mouth breathing, nursing bottles Pacifiers, etc.	☐YES	☐NO	Explain:
Any unusual speech habits	☐YES	☐NO	Explain:
Any lost teeth	☐YES	☐NO	Explain:
Have missing teeth been replaced	☐YES	☐NO	Explain:
Orthodontic appliances worn now or ever been	☐YES	☐NO	Explain:
Does your child brush their teeth daily?	☐YES	☐NO	How Often:
Do you assist your child with tooth brushing?	☐YES	☐NO	Who assists:
Is dental floss used?	☐YES	☐NO	How Often:
Is fluoride supplement taken in any form?	☐YES	☐NO	Explain:

Health History			
Physician:	Phone No		Date of last exam
Is your child under the care of a physician now?	☐YES	☐ NO	Explain:
Is your child receiving any medication or drugs?	☐YES	☐NO	Explain:
Is there any excessive bleeding when cut?	☐YES	☐NO	Explain:
Has your child ever been hospitalized?	☐YES	☐NO	Explain:
Has your child ever had surgery?	☐YES	☐NO	Explain:
Is there any allergy to penicillin or other drugs?	☐YES	☐NO	Explain:
Are there other allergies?	☐YES	☐NO	Explain:
Does your child have good physical coordination?	☐YES	☐NO	Explain:
Are there any emotional problems?	☐YES	☐NO	Explain:
Any other health history (for doctor's use):	☐YES	☐NO	Explain:

Has your child had a history of or difficulty with any of the following?

☐ ADD/ADHD	☐ Bladder	☐ Convulsions	☐ Epilepsy	☐ Liver	☐ Mononucleosis	☐ Tuberculosis
☐ Anemia	☐ Cerebral Palsy	☐ Diabetes	☐ Fainting	☐ Malignancies	☐ Mumps	☐ Venereal
☐ Asthma	☐ Chicken Pox	☐ Disease	☐ Hearing	☐ Mastoid	☐ Rheumatic Fever	
☐ Autism	☐ Chronic sinus	☐ Eczema	☐ Kidney	☐ Measles	☐ Thyroid	☐ Other: _____

Has your child had any other serious illness not listed? YES NO

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform Honolulu Keiki Dental of any changes in medical status.

May we request release of your child's medical records? YES NO

This information was discussed with and given by: _____ Date: _____

Relation to child: _____

Consent Form

Prior to using or disclosing your protected health information to carry out treatment, payment or health care operations, the office of Honolulu Keiki Dental is required under federal law to obtain your consent. If you agree with its terms, please sign and date this consent below.

Should you desire a more complete description of the permissible uses and disclosures of your protected health information, you have the right to review a Notice of Privacy Practices (the "Notice") prior to signing this consent.

By signing this consent, you agree that we may use or disclose your protected health information to carry our treatment, payment or health care operations.

You have the right to request restrictions how your protected health information is used or disclosed to carry out treatment, payment or health operations. However, we are not required to agree to such restrictions. If we agree to a restriction that you request, such restriction will be binding.

You have the right to revoke this consent in writing, except to the extent that we have taken action in reliance on your consent.

I, _____ (name of parent/guardian/patient), hereby certify that I have read the provisions set forth in this consent. I understand and agree to the terms of this consent. I understand that this consent is between myself and Honolulu Keiki Dental. (with regards to my child(ren) _____). This consent form will be kept in the patient file and remain effect until written cancellation.

_____ _____

Print Name Date

_____

Signature of Parent/Guardian/Patient

Financial Responsibility

Dear Parent/Guardian,

In order to determine financial responsibility of your children's dental account, we would like the following to be approved, signed, and returned to our office. Thank you for your cooperation.

I, _____, hereby authorize that all necessary dental services and methods be rendered for my child/children, _____ and I assume financial responsibility for their dental account.

(Consent shall remain in force and in effect until canceled)

Signature: _____

Date: _____

No Show/Missed Appointment Policy

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted one (1) business day prior to your scheduled appointment.

We understand that sometimes emergencies occur and you need to cancel or reschedule your appointment. If you are unable to keep your appointment, Please call us as soon as possible (with at least a 24-hour notice (808) 944-1603).

To maintain the quality and efficient patient scheduling for you and all of our patients we have instilled a broken appointment policy. A broken appointment (a missed dental appointment without prior notification) not only causes undue hardships for our employees but also leaves a space in our appointment schedule that could be filled by a child with significant and urgent dental needs.

When a family misses their dental appointment, without prior to notification, that family and their child(ren) may be subject to dismissal from our dental office.

We truly value you and your family as well as the trust that you have given us. All we ask is that you give us a call if you can't make it to your appointment. We would like you to sign below and return this to our front office staff.

I have read and understand Honolulu Keiki Dental's No Show/Missed Appointment Policy and I understand my responsibility to plan appointments accordingly and notify Honolulu Keiki Dental appropriately if I have difficulty keeping my scheduled appointments.

_____ _____ _____

Patient(s) Name Date of Birth(s) Date

_____ _____

Patient Signature or Parent/Guardian if minor Relationship to Patient

HIPAA

Dear Parents/Guardians,

The federal government passed a law called the Health Insurance Portability Accountability Act (HIPAA) which enhances patient's rights to have their health information kept private. The compliance date for this law is April 14, 2003.

This law changes certain aspects on how we conduct the business of dentistry. This law DOES NOT change our quality of dentistry. This law DOES NOT change how we treat our patients. Although it involves more work on our part, I think it's a good law because it benefits the patient.

This law requires that each patient (parent) receive a "Notice of Privacy Practices" which describes how your dental information may be used and disclosed. The law also requires that we obtain, from you, a signed receipt of this notice. This law also requires that we also obtain a signed consent from you saying you agree with this notice. Patients that are 18 years old and older need to sign their own form. When you next visit our office you may sign these forms. If you don't accompany your child on your next visit, you need to make arrangements to have these forms signed. As of April 14, 2003 the law requires us not to see any patients who do not have these forms signed.

We apologize for any inconveniences this may cause you. We also greatly appreciate your trust and the privilege to serve you and your children. If you have any questions, please feel free to call us.

Sincerely,

Honolulu Keiki Dental

Signature: _____

Device

We welcome parents/guardians to be present in the treatment areas for their child's appointment if they choose to do so. However, to ensure the comfort, safety, and security of our patients, the privacy of our staff members, and to comply with our HIPPA laws, we kindly ask that you to **refrain from using any cell phones, video, or cameras in the treatment area.** Thank you in advance.

I agree to comply with request above

_____

Print Name

_____ _____

Signature Date