NEW PATIENT REGISTRATION

Patient Name : _____ **Nickname**: _____
(Last Name, First Name, Middle initial.)
Age:_____ **Birth Date**:_____ **Gender**: **M F** **School**: _____ **Grade**: _____
Address:_____ **City**:_____ **State**: _____ **Zip code**:_____
Child's Favorites: Sport _____ **Toy** _____ **Hobby** _____ **Person**_____ **Fictional Character**_____

Father's Name: _____ **Marital Status: Single** ☐ **Married** ☐ **Divorced** ☐
(Last Name, First Name, Middle initial.) **Widowed** ☐ **Legally Separated** ☐
Father Cell Phone #: _____ **Home Phone:** _____
Birth Date: _____ **Social Security**: _____
(For insurance purposes)
Occupation: _____ **Employer**: _____ **Work Phone #:** _____

Mother's Name: _____ **Marital Status: Single** ☐ **Married** ☐ **Divorced** ☐
(Last Name, First Name, Middle initial.) **Widowed** ☐ **Legally Separated** ☐
Mother Cell Phone #: _____ **Home Phone:** _____
Birth Date: _____**Social Security**: _____
(For insurance purposes)
Occupation: _____ **Employer**: _____ **Work Phone #:** _____

Person Financially Responsible (if other than parent) Guardian ☐ State Worker ☐ Relative ☐
Name: _____ **Relationship to Patient**: _____**Phone#**: _____

Billing Address (if different from address above) ☐ Check box if address is the same above
Address:_____ **City**:_____ **State**:_____ **Zip code**:_____

Whom may we thank for referring you: _____

INSURANCE INFORMATION

Primary Insurance: _____ **Subscriber's Name:** _____ **Subscriber ID #**_____
(Insurance Carrier Name)
Secondary Insurance: _____ **Subscriber's Name:** _____ **Subscriber ID #** _____
(Insurance Carrier Name)
Other Insurance: _____ **Subscriber's Name:** _____ **Subscriber ID #**_____
(Insurance Carrier Name)

(SEE BACK PAGE FOR HEALTH HISTORY)

DENTAL HISTORY

Last Dental Visit: _____ **What Service Was Performed**: _____

Childs Attitude towards dentistry: _____

	Yes	No	
Is your child in any dental pain?	☐	☐	Explain: _____
Any injuries to teeth/mouth/head?	☐	☐	Explain: _____
Any Habits (Thumb sucking, nail biting mouth breathing, nursing bottle habits, pacifier, etc.)	☐	☐	Explain: _____
Unusual Speech Habits	☐	☐	Explain: _____
Any Lost Teeth	☐	☐	Explain: _____
Have missing teeth been replaced?	☐	☐	Explain: _____
Has patient previously had or have an Orthodontic Appliance?	☐	☐	Explain: _____
Does your child brush Daily?	☐	☐	How Many Times: _____
Do you assist your Child with brushing?	☐	☐	Who assists your child with brushing? _____
Does your child use Dental Floss?	☐	☐	How often: _____
Does Your Child take fluoride Vitamins?	☐	☐	What type of fluoride? _____

HEALTH HISTORY

Childs Physician: _____ **Phone**: _____ **Last Physical Exam**: _____

	YES	NO	
Is your child under the care of his/her physician?	☐	☐	Reason: _____
Allergies to penicillin or other drugs?	☐	☐	Explain: _____
Any other allergies?	☐	☐	Type : _____
Seasonal Allergies?	☐	☐	
Is Your Child taking Medications?	☐	☐	Medications: _____
Is there any excessive bleeding when they are cut?	☐	☐	
Has your child been hospitalized?	☐	☐	Explain: _____
Has your child ever had surgery?	☐	☐	Explain:_____
Does your child have good physical coordination?	☐	☐	
Are there any emotional problems?	☐	☐	
Health History You would like Doctor to know?	☐	☐	Explain: _____

_____

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

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

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

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

Name of person who filled form: _____ **Relationship to Patient**: _____

Signature : _____ **Date**: _____

Consent Form

Prior to using or disclosing your protected health information to carry out treatment, payment or health care operations, the office of Kapolei 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, _____ hereby certify that I have read the provisions set forth in this consent.
(Parent or Guardian Name)

I understand and agree to the terms of this consent. I understand that this consent is between me and the office of Kapolei Keiki Dental.

(With regards to my child/children _____)
(Name of Child/ Children)

This consent form will be kept in the patient file and remain effect until written cancellation.

_____
Print Name

_____ _____
Signature Date
(Parent / Guardian / Patient over 18 years of age)

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 you cooperation.

I, _____, hereby authorize that all necessary dental services and methods be
(Parent or Guardian Name)
rendered for my child/children _____.
(Name of Child/Children)
And I assume financial responsibility for their dental account.

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

Name: _____

Signature: _____

Date: _____

Broken Appointment / Late Cancellation Policy

Dear Parents/Guardians,

To ensure the quality of service and provide 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 my 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 a dental appointment without prior notification, that family and their child(ren) may be subject to dismissal from our dental practice, after 3 Broken Appointments / Late cancellations.

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

Mahalo,

Kapolei Keiki Dental

From this day forward, I understand and agree to the terms stated above.

Print Your Name _____

Your Signature _____

Today's Date _____

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,

Kapolei Keiki Dental

Print Name: _____

Signature: _____