WAIMEA SMILES

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65-1230 Mamalahoa Highway
Kamuela, Hawaii 96743
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Welcome to Our Practice

Taking care of our patients is our main priority. We take pride in our ability to provide you with high quality dental care designed for your unique needs and desires. The focus of our practice is health-centered, preventative dentistry. We enjoy helping our patients actively participate in their own health care and control the causes of dental disease. Further, we emphasize comprehensive treatment designed for long-term health and function.

Our staff members are devoted to making your appointments as pleasant and enjoyable as possible. We will reserve time in our schedule just for you. As a courtesy, we will send you reminders and we ask that you return that courtesy with a response. If you are unable to make an appointment, we do ask for an advance notice of at least 2 full business days, so that we may offer the reserved time to another patient. Except in the case of an emergency or illness, there will be a $75 charge for all appointments rescheduled in less than 2 full business days of your reserved time.

Hygiene appointments are not just cleanings, they are clinical appointments to assess the current condition of your oral health. At each of these visits our personable and highly skilled doctor and hygienists assess your home care and dietary habits, complete gum and tooth health diagnostics and perform an oral cancer screening. Frequency of your hygiene appointments will be established by your overall gum health.

We understand patient concerns on the safety of dental x-rays. They are necessary diagnostic tools to visualize cavities and conditions between and at the root of teeth. We limit the amount of radiation to our patients by utilizing digital imaging, lead aprons and the ALARA (as low as reasonably achievable) principle. X-ray frequency is determined by each patient's current dental condition, restorative history and risk for cavities.

I have read and agree to the Waimea Smiles Practice Policy.

Signature_____ Date _____ By _____

Patient Name _____ Relationship_____

Release of Information/Dental Benefits Assignment/Financial Agreement

RELEASE OF INFORMATION: I authorize Waimea Smiles, 1) to perform diagnostic procedures and treatment as may be necessary for proper dental care. 2) I authorize release of any information concerning my (or my Child's) health care, advice and treatment to another dentist or health care provider.

DENTAL BENEFITS ASSIGNMENT: I authorize release of any information concerning my (or my child) health care, advice and treatment provided for the purpose of evaluating and administering claims benefits. I hereby authorize payment of dental benefits directly to the dentist otherwise payable to me. I understand that if I have coverage with a dental plan other than HDS or Delta Dental, payment of benefits will be sent directly to me.

FINANCIAL AGREEMENT: I understand I am financially responsible for payments in full of all accounts. I agree to pay the non-dental benefits portion of treatment costs at the time of service. I understand that my dental carrier or payor of my dental benefits may pay less than the actual bill for services. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor. I understand that if I have coverage with a dental carrier other than HDS or Delta Dental or no dental benefits, I will need to pay for services in full at the time of service. I also understand that there will be a $25.00 service fee assessed for any returned checks. Balances not paid in full after 60 days, will incur a monthly fee of 8.4%.

I certify that I am the patient or am duly authorized by the patient as the patient's agent to execute this document and to accept its terms.

_____	_____	_____
Signature	Date	Relationship, if other than patient

PATIENT'S
NAME _____
Last First

IF CHILD
PARENT'S NAME _____
Last First

PREFERRED
NAME _____

MALE ☐ FEMALE ☐

Single ☐ Married ☐ Separated ☐

Divorced ☐ Widowed ☐ Minor ☐

CONTACT INFORMATION

MAILING
ADDRESS _____

CITY _____ STATE _____

ZIP _____

TELEPHONE
RESIDENCE:_____

BUSINESS: _____

CELL: _____
Please indicate best number to reach you at:
☐ RES. ☐ BUS. ☐ CELL

EMAIL:_____

Would you like to receive reminders via email or text message? (Check all that apply)

EMAIL ☐ TEXT ☐

I authorize Waimea Smiles Inc to contact me on my cellphone regarding my account and insurance information _____ (initials)

DATE_____ DATE OF BIRTH_____

PATIENT/PARENT
EMPLOYED BY_____

PRESENTPOSITION _____

HOWLONG _____

GUARANTOR
FORACCOUNT _____

DRIVER'S LICENSE
NO. _____

OTHER FAMILY MEMBERS
IN THIS PRACTICE _____

_____

HOW DID YOU HEAR ABOUT US?

☐ REFERRED BYWHOM? _____
☐ INTERNET (Google, Website, Facebook, Yelp, etc.)
☐ HDS or Delta

EMERGENCYCONTACT _____

PHONE_____

PRIMARY DENTAL BENEFIT PLAN

YES ☐ NO ☐

SECONDARY DENTAL BENEFIT PLAN

YES ☐ NO ☐

(Please give your insurance card(s) to the front office staff)

CONFIDENTIAL HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

I. CIRCLE/HIGHLIGHT APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes/No Is your general health good?
   If NO, explain _____
2. Yes/No Has there been a change in your health within the last year?
   If YES, explain _____
3. Yes/No Have you gone to the hospital or emergency room or had a serious illness in the last three Years?
   If YES, explain _____
4. **Who is your current Physician?** _____
5. Yes/No Are you currently being treated by your Physician for any condition?
   If YES, explain _____
   Date of last medical exam_____ Reason for exam_____
6. Yes/No Have you had any problems with prior dental treatment?
   If YES, explain _____
   Date of last dental exam_____
   Name of last treating dentist_____ Tel _____
7. Yes/No Are you in pain now?
   If YES, explain _____
8. Yes/No Have you made regular dental visits?
9. Yes/No Do you clench or grind your teeth?
10. Yes/No Does your jaw click or pop?
11. Yes/No Have you experienced any soreness in the muscles of your face around your ear?
12. Yes/No Do you have frequent headaches, neck aches or shoulder aches?
13. Yes/No Does food get caught in your teeth?
14. Yes/No Are any of your teeth sensitive to: ☐Hot? ☐Cold? ☐Sweets? ☐Pressure?
15. Yes/No Are any of your teeth loose, tipped, shifted or chipped?
16. Yes/No Do your gums bleed or hurt? When?_____
17. Yes/No How often do you brush your teeth?_____ When? _____
18. Yes/No Do you use dental floss? How often? _____
19. Yes/No Do you feel your breath is offensive at times?
20. Yes/No Have you ever had gum treatment or surgery? What? _____
    Where?_____ When? _____
21. Yes/No Are you unhappy with the appearance of your teeth?
22. Yes/No Have you had any unpleasant dental experiences or is there anything about general dentistry that you strongly dislike?_____

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please circle/highlight Yes or No for each)

Yes/No	Chest pain (angina)	Yes/No	Blood in stools	Yes/No	Frequent vomiting
Yes/No	Fainting spells	Yes/No	Diarrhea or constipation	Yes/No	Jaundice
Yes/No	Recent significant weight loss	Yes/No	Frequent Urination	Yes/No	Dry Mouth
Yes/No	Fever	Yes/No	Difficulty urinating	Yes/No	Excessive thirst
Yes/No	Night Sweats	Yes/No	Ringing in ears	Yes/No	Difficulty Swallowing
Yes/No	Persistent Cough	Yes/No	Headaches	Yes/No	Swollen ankles
Yes/No	Coughing up blood	Yes/No	Dizziness	Yes/No	Joint pain or stiffness
Yes/No	Bleeding problems	Yes/No	Blurred Vision	Yes/No	Shortness of breath
Yes/No	Blood in urine	Yes/No	Bruise Easily	Yes/No	Sinus problems

Other: _____

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle/highlight Yes or No for each)

Yes/No	Heart disease	Yes/No	AIDS/HIV	Yes/No	Psychiatric Care
Yes/No	Family history of heart disease	Yes/No	Surgeries	Yes/No	Osteoporosis
Yes/No	Artificial joint/stent/shunt	Yes/No	Hospitalization	Yes/No	Thyroid disease
Yes/No	Heart attack	Yes/No	Diabetes	Yes/No	Asthma
Yes/No	Stomach problems or ulcers	Yes/No	Family history of diabetes	Yes/No	Hepatitis
Yes/No	Heart defects	Yes/No	Tumors or cancer	Yes/No	Sexual transmitted disease
Yes/No	Heart Murmurs	Yes/No	Chemotherapy	Yes/No	Herpes
Yes/No	Rheumatic fever	Yes/No	Radiation	Yes/No	Canker or cold sores
Yes/No	Skin Disease	Yes/No	Arthritis, rheumatism	Yes/No	Anemia
Yes/No	Hardening of Arteries	Yes/No	Emphysema or other lung disease	Yes/No	Liver disease
Yes/No	High blood pressure	Yes/No	Kidney or bladder disease	Yes/No	Eye disease
Yes/No	Seizures	Yes/No	Stroke	Yes/No	Transplants
Yes/No	Cosmetic surgery	Yes/No	Eating disorders	Yes/No	Tuberculosis

Hospitalization (specify): _____ Surgeries (specify): _____

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle/highlight Yes or No for each)

Yes/No	Aspirin	Yes/No	Valium or other sedatives	Yes/No	Codeine or other narcotics
Yes/No	Penicillin or other antibiotics	Yes/No	Latex	Yes/No	Food
Yes/No	Nitrous Oxide	Yes/No	Local anesthetic	Yes/No	Metal

Others: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please circle /highlight Yes or No for each)

Yes/No	Recreational Drugs	Yes/No	Tobacco in any form	Yes/No	Antibiotics
Yes/No	Over-the-counter medicines	Yes/No	Alcohol	Yes/No	Supplements
Yes/No	Weight loss medications	Yes/No	Bisphosphonate (Fosamax, etc.)	Yes/No	Aspirin
Yes/No	Anti-Depressants	Yes/No	Herbal Supplements		

Please list all prescription medications and what for: _____

_____

VI: WOMEN ONLY (Please circle/highlight Yes or No for each)

Yes/No Are you or could you be pregnant?
If YES, what month? _____ Due Date? _____

Yes/No Are you nursing?

Yes/No Are you taking birth control pills?

VII. ALL PATIENTS (Please circle/highlight Yes or No for each)

Yes/No Do you have or have you had any other diseases on medical problems NOT listed on this form?
If YES, please explain _____

_____

Yes/No Have you ever been pre-medicated for dental treatment? If YES, why: _____

Yes/No Have you ever taken Fen-Phen? If YES, when:_____

Yes/No Have you had the Human Papillomavirus (HPV) vaccine (Gardasil, Ceravix)?

Yes/No Have you ever had a positive diagnosis of the Human Papillomavirus?

Yes/No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature _____ Date _____

Physician's Name _____ Phone Number _____

Whom would you like us to contact in case of an emergency?

Name: _____ Relationship: _____ Phone Number: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian) Date Signature of Dentist Date

WAIMEA SMILES
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____ _____
{Signature} {Date}

In addition to allowable disclosures described in the notice of privacy practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:

Any member of my immediate family __Yes __No
Spouse Only __ Yes __No
Other: (please specify)_____

I understand that I can revoke these additional authorizations at any time by calling 887-8801 or emailing the office at info@waimeasmiles.com.

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (please specify)

How Your Health Information May Be Used

To Obtain Payment
We may include your health information to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically.

To Provide Treatment
We will use your Health Information within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing you treatment.

For Law Enforcement
As permitted or required by State or Federal Law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers
We may share your health information with persons you authorize. In the case of an emergency, we will use our very best judgement when sharing your health information.

Authorization to Use or Disclose Health Information
Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke the authorization in writing at any time.

To Conduct Health Care Operations
Your health information may be reviewed for staff training, insurance audits or the routine processes of certification, licensing or credentialing activities.

Public Health and National Security
We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security.

In Patient Reminders
We believe regular care is very important and will contact you via postcard, letter, email, telephone or fax to remind of scheduled appointments, recalls or follow-up care. You have the right to request we contact you in a certain way.

Abuse or Neglect
We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence.

Patient Rights

Confidential Communications
You have the right to request restrictions on certain uses and disclosures of your health information. You have the right to request we communicate with you in a certain way, i.e. mail, telephone, etc. We will honor reasonable requests.

Inspect and Copy Your Health Information
You have the right to read, review and copy your health information. Charges may apply.

Amend Your Health Information
You have the right to ask us to update or modify your records if you feel they are incorrect or incomplete. Requests must be made in writing and may be denied.

Documentation of Health Information
You have the right to ask us for a description of when your health information was used for purposes other than treatment, payment or other health care operations. A fee may apply.

Request a Paper Copy of this Notice
Our office is required to give you a copy of our Privacy Practices.

E-MAIL WAIVER

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) sets standards for protecting the rights of individuals (patients). Waimea Smiles Inc. follows the laws that grant every individual the right to privacy and confidentiality of their personal and health information. To comply with HIPAA regulations, e-mail correspondence that contains protected personal and health information must be sent encrypted (secured). Each time you receive an encrypted message from our office, you will need to obtain a one-time password to open the message. Instructions are sent with the encrypted message. If you wish to have unencrypted (un-secure) e-mail sent to you for the sake of your convenience, you must sign the following waiver:

I, _____ request that, for my convenience, Waimea Smiles Inc. correspond with me by unencrypted (unsecure) e-mail. I understand that e-mails sent to me may contain personal and/or protected health information. I further understand that unencrypted e-mail and e-mail attachments are not secure and may be viewed by others. I agree to hold harmless Waimea Smiles Inc., its officers, agents, employees and contract health providers from any and all liability, loss, damages, costs, or expenses which are sustained, incurred, or required arising from the transmission of unencrypted (unsecure) e-mail correspondence and attachments.

I hereby direct Waimea Smiles Inc. to send all emails in an unencrypted (unsecure) format to this address:

This waiver will remain in force until revoked in writing. It may revoked in writing at any time

Signed and dated _____

_____