Patient Information

Date_____ ☐Male ☐Female ☐Married ☐Single ☐Divorced ☐Separated ☐Student

Last Name_____ First Name_____ Middle_____

Address _____ City _____ State _____ Zip _____

E-mail Address_____ Social Security #_____ Date of Birth_____

Home #_____ Work #_____ Cell # _____

Employer _____ Phone # _____

If patient is a minor, give parents or guardian's name_____

Name of nearest relative not living with you_____

Complete Address_____ Phone # _____

Whom may we thank for referring you to our office? ☐Patient _____

☐Yellow Pages ☐Location ☐Money Mailers ☐1-800 Dentist ☐News Paper ☐Other_____

Responsible Party Information

Last Name_____ First Name_____ Middle_____

Address _____ City _____ State _____ Zip _____

Home #_____ Work #_____ Cell # _____

Previous Address (if less than 3 yrs.)_____

Social Security # _____ Date of Birth _____ Relationship to Patient_____

Employer_____ Occupation _____ No. Years Employed _____

Address_____ Phone # _____

Spouse Information

Last Name_____ First Name_____ Middle_____

Address _____ City _____ State _____ Zip _____

Home #_____ Work #_____ Cell # _____

Social Security # _____ Date of Birth _____ Relationship to Patient_____

Employer_____ Occupation _____ No. Years Employed _____

Address_____ Phone # _____

Dental Insurance Information

Primary Dental Insurance	Secondary Dental Insurance
Insured's Name_____	Insured's Name_____
Insured's Date of Birth_____	Insured's Date of Birth_____
Insured's Phone #_____	Insured's Phone #_____
Insured's Social Security #_____	Insured's Social Security #_____
Insurance Company _____	Insurance Company _____
Company Address _____	Company Address _____
_____	_____
Insurance Company Phone # _____	Insurance Company Phone # _____
Insured's Employer _____	Insured's Employer _____

Dental Information

Do your gums bleed when you brush? ☐ Yes ☐No Are your teeth sensitive to heat or cold? ☐ Yes ☐No

Are your teeth sensitive to Pressure? ☐ Yes ☐No Do you have a fear of the dentist? ☐ Yes ☐No

Do you grind or clench your teeth? ☐ Yes ☐No Have you had your teeth bleached before? ☐ Yes ☐No

How do you feel about the appearance of your teeth? Do you: ☐Love them ☐Accept them ☐Want to change them

How do you feel about the appearance of your smile? Do you: ☐Love it ☐Accept it ☐Want to change it

Date of Last Examination _____ What was done at that time?_____

Are you interested in using Nitrous Oxide (Laughing Gas) ..... ☐Yes ☐No

PLEASE COMPLETE THE INFORMATION ON THE BACK PAGE

Medical History Information

1. Describe your current dental problem(s)?_____

_____

2. Are you having pain or discomfort at this time? ☐Yes ☐No
3. Have you been a patient in the hospital during the past two years? ☐Yes ☐No
4. Have you been under the care of a medical doctor during the past two years? ☐Yes ☐No

   Physician's Name_____ Phone Number _____

   Address_____
5. Have you taken any medication or drugs in the past two years? ☐Yes ☐No
6. **Are you now taking any medication or drugs? (includes medication for pain, recreational drugs, and hormones)** ☐Yes ☐No

   If yes, please list:_____
7. **Are you currently taking any type of Herbal Supplements?** ☐Yes ☐No

   If yes, please list:_____
8. **Are you sensitive or allergic to any medication or anesthetics?** ☐Yes ☐No

   If yes, please list:_____
9. Have you ever taken the diet drug Phen-Phen? ☐Yes ☐No
10. Indicate which of the following you have had or have at the present. Check "yes" or "no" for each item.

Heart Failure	☐Yes ☐No	*Artificial Joints (hip, knee, etc.)	☐Yes ☐No	Hepatitis B (serum)	☐Yes ☐No
Heart Disease or Attack	☐Yes ☐No	Kidney Trouble	☐Yes ☐No	Hepatitis C	☐Yes ☐No
Angina Pectoris	☐Yes ☐No	Ulcers	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Congenital Heart Disease	☐Yes ☐No	Diabetes	☐Yes ☐No	A.I.D.S.	☐Yes ☐No
*Heart Murmur	☐Yes ☐No	Thyroid Problems	☐Yes ☐No	H.I.V. Positive	☐Yes ☐No
High Blood Pressure	☐Yes ☐No	Glaucoma	☐Yes ☐No	Cold Sores/Fever Blisters	☐Yes ☐No
Arteriosclerosis	☐Yes ☐No	Cancer	☐Yes ☐No	Hemophilia	☐Yes ☐No
*Mitral Valve Prolapse	☐Yes ☐No	Emphysema	☐Yes ☐No	Anemia	☐Yes ☐No
Artificial Heart Valve	☐Yes ☐No	Chronic Cough	☐Yes ☐No	Sickle Cell Disease	☐Yes ☐No
*Heart Pacemaker	☐Yes ☐No	Tuberculosis	☐Yes ☐No	Bruise Easily	☐Yes ☐No
Heart Surgery	☐Yes ☐No	Asthma	☐Yes ☐No	Liver Disease	☐Yes ☐No
*Rheumatic Fever	☐Yes ☐No	Hey Fever	☐Yes ☐No	Yellow Jaundice	☐Yes ☐No
Arthritis	☐Yes ☐No	Allergies or Hives	☐Yes ☐No	Epilepsy or Seizures	☐Yes ☐No
Rheumatism	☐Yes ☐No	Sinus Trouble	☐Yes ☐No	Fainting or Dizzy Spells	☐Yes ☐No
Cortisone Medicine	☐Yes ☐No	Radiation Therapy	☐Yes ☐No	Nervousness	☐Yes ☐No
Drug Addiction	☐Yes ☐No	Chemotherapy	☐Yes ☐No	Tumors	☐Yes ☐No
Stroke	☐Yes ☐No	Hepatitis A (infectious)	☐Yes ☐No	Developmentally Disabled	☐Yes ☐No
Low Blood Pressure	☐Yes ☐No	Breathing Problems	☐Yes ☐No	Frequent Diarrhea	☐Yes ☐No
Blood Disease	☐Yes ☐No	Shortness of Breath	☐Yes ☐No	Excessive Thirst	☐Yes ☐No
Hypoglycemia	☐Yes ☐No	Pain in Jaw Joints	☐Yes ☐No	Alzheimer's Disease	☐Yes ☐No

11. Do your ankles swell during the day? ☐Yes ☐No
12. Have you lost or gained more than 10 pounds in the past year? ☐Yes ☐No
13. Are you on a special diet? ☐Yes ☐No
14. Do you have or have you had any disease, condition, or problem not listed? ☐Yes ☐No

    If yes, please list:_____
15. Do you use tobacco products? ☐Yes ☐No
16. Do you use alcohol products? ☐Yes ☐No

FOR WOMEN ONLY:

17. Are you pregnant? ☐Yes ☐No If yes, what month?_____ Are you nursing? ☐Yes ☐No
18. Are you taking birth control pills? ☐Yes ☐No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. In the event of non-payment for dental services received, the undersigned agrees to pay all lawyer fees, court costs, and collection fees up to 50%, if turned over to a outside collection agency.

PATIENT SIGNATURE_____ **DATE**_____

PARENT OR RESPONSIBLE PARTY _____ **RELATIONSHIP TO PATIENT** _____

Medical Review: Reviewed by:_____ Date_____
Reviewed by:_____ Date_____
Reviewed by:_____ Date_____

Medical History Update by Patient: Initials_____ Date_____
Initials_____ Date_____
Initials_____ Date_____

CONSENT TO PROCEED

I authorize the doctors of Aloha Dental, such associates, or assistants as they might designate to perform those procedures as may be deemed necessary, or advisable to maintain my dental health, or the dental health of any minor, other individual for which I have responsibility. This includes arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or pharmaceutical agent(s), including those related to restorative, palliative, therapeutic, or surgical treatments.

I understand that the administration of local anesthetic man cause untoward reaction or side effects, which may include, but are not limited to: brushing, hematoma, cardiac stimulation, and temporary, or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as a part of dental treatment, including preventative procedures such as cleaning and basic dentistry including: filling of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointment, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, check or the oral tissue to be inadvertently abraded or lacerated during routine dental procedures. In some cases sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components exedra may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician, or hospital and may in rare cases, required bronchoscope, or other procedures to ensure the safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis may result in complication of non-healing of the jaw bones following oral surgery.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results; which may or may not be achieved for my benefits, or the benefits of a minor or other individual responsible for. I acknowledge that the nature and purpose of the foregoing procedure have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name: _____

Signature: _____ Date: _____

(Patient, Legal guardian, or authorized agent of patient)

Witness:_____ Date: _____

FINANCIAL AND INSURANCE POLICIES

Thank you for choosing us as your dental care provider. We are anxious to serve you and are committed to providing the best care possible. Payment is due at time of treatment. In order to make your dental care financially comfortable, we offer the following financial options. Please check the option(s) that will be the most comfortable for you.

- **Payment in Full Courtesy.**
  A prepayment courtesy of 5% will be subtracted from the total patient obligation if the patient obligation is **paid in full.**

- **Outside Financing.**
  Our office uses Unicorn Financial for patients to finance their dentistry. They have options ranging from 6 to 24 months interest free financing based on the amount financed.

- **No Dental Insurance Discount (25% with the Aloha Dental Plan).**
  Patients without dental insurance will be given a 25% when they sign up for the Aloha Dental Plan (ask for details). This offer cannot be combined with the "Payment in Full Courtesy" listed above.

NO SHOW/LATE CANCELLATION FEE:

As of May 1, 2012, Aloha Dental will enforce a $25.00 no show or cancelling an appointment within a 24 hour period appointment fee. All appointments must be cancelled or moved at least 24 hours prior to your appointment or the fee will be assessed to your account.

We accept Cash, Visa, MasterCard, Discover, American Express, Money Order, Personal Checks

INSURANCE

It is our pleasure to assist you in maximizing your insurance benefit by completing your claim forms. At the time of service we will ask you to pay your **estimated** co-payment. Please understand that this is only an **estimate**, and is based upon the information available to us.

Insurance benefit coverage depends solely on what your employer wishes to purchase. Some plans cover as little as 30% or as much as 100% of dental services, with most falling in the 40% to 80% range. Some plans base the amount of benefit on a schedule of fees arbitrarily developed by insurance companies. For this reason, you may receive a lower percentage than the reimbursement level indicated in your dental plan. For example, if your plan states that it will pay 80% of the cost of a specific treatment, it means 80% of the fee arbitrarily determined by the insurance company and not the actual fee charged by our office.

The **financial obligation for dental treatment is between you and our office. The insurance company is responsible to you, and not to our office.** We will assist you in any way we can. Any amount owing after your insurance company has paid will be due from you upon receipt of our statement. If for any reason we have not received your insurance carrier's payment 90 days after the claim was submitted, the remaining balance will be due and payable by you and subject to 21% APR. Should the account be referred to an attorney or collection agency, I will pay all cost of collection, including up to 40% collection fee, as well as court costs and a reasonable attorney fee. I allow the below signature to be held as a signature on file for all insurance claims and/or telephone /mail/credit card payments.

Patient's Signature _____ Date_____

Parent or Responsible Party _____ Relationship to Patient _____

WE ARE PLEASED TO HAVE YOU AS OUR PATIENT

AUTHORIZATION FOR SIGNATURE ON FILE

I, _____ and/or _____
Name of Patient (Parent of Guardian if Minor) Name of Insured

hereby authorize **Aloha Dental** to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my employment with _____.
(Employer of Insured)

I hereby authorize payment of dental benefits, otherwise payable to me, directly to the office listed above. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. To the extent permitted under applicable law, I authorize release of any information relating to the claim. This "Authorization" will be valid from this date and shall expire in one year. A photocopy of this document may act as an original.

_____ _____
Signature of Insured Date

_____
Witnessed by

Today's Date _____

Exp. Date _____

ACKNOWLEDGEMENT OF RECEIPT OF OFFICE PRIVACY POLICIES

I, _____, have received a copy of the office's Privacy Policies.

_____

Name (Please Print)

_____Date:_____

Signature