REGISTRATION FORM

SECTION 1 PATIENT INFORMATION

DATE

LAST NAME | FIRST | M.I. | SEX ☐ MALE ☐ FEMALE | SOCIAL SECURITY NUMBER ___ - ___ - ____

ADDRESS | APT # | CITY | STATE | ZIP | BIRTH DATE / /

PLACE OF EMPLOYMENT (OR SCHOOL) | GRADE | HOME PHONE | OFFICE PHONE | HAS ANY MEMBER OF YOUR FAMILY EVER BEEN TREATED IN OUR OFFICES? ☐ YES ☐ NO

SECTION 2 DENTAL INSURANCE COVERAGE(S)

INSURANCE COMPANY | POLICY NUMBER | EFFECTIVE DATE / /

EMPLOYER | GROUP NUMBER

SUBSCRIBER LAST NAME | FIRST | M.I. | RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ PARENT ☐ GUARDIAN

BIRTH DATE / / | SEX ☐ MALE ☐ FEMALE | SOCIAL SECURITY NUMBER ___ - ___ - ____ | HOME PHONE | OFFICE PHONE

SECONDARY INSURANCE (If Applicable)

INSURANCE COMPANY | POLICY NUMBER | EFFECTIVE DATE / /

EMPLOYER | GROUP NUMBER

SUBSCRIBER LAST NAME | FIRST | M.I. | RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ PARENT ☐ GUARDIAN

BIRTH DATE / / | SEX ☐ MALE ☐ FEMALE | SOCIAL SECURITY NUMBER ___ - ___ - ____ | HOME PHONE | OFFICE PHONE

SECTION 3 ACCOUNT RESPONSIBLE PARTY

LAST NAME | FIRST | M.I. | SEX ☐ MALE ☐ FEMALE | SOCIAL SECURITY NUMBER ___ - ___ - ____

ADDRESS | APT # | CITY | STATE | ZIP | BIRTH DATE / /

RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ PARENT ☐ GUARDIAN ☐ OTHER (EXPLAIN)

PLACE OF EMPLOYMENT | OFFICE PHONE | HOME PHONE

PERSON TO CONTACT IN CASE OF EMERGENCY | OFFICE PHONE | HOME PHONE

AUTHORIZATION

I accept the financial responsibility of this account. The information on this page is correct to the best of my knowledge.

ACCOUNT RESPONSIBLE PARTY | DATE

FORM 203 (REV 5-91) | ACCOUNT NUMBER | PATIENT INFORMATION

PATIENT NAME _____ **DATE** _____
LAST FIRST M.I.

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

DENTAL HISTORY

PLEASE CIRCLE

Do you have a specific dental problem? Describe	YES NO
Do you have dental examinations on a routine basis? Last visit	YES NO
Would you describe your present dental health as good? Comments	YES NO
Do you think you have active decay or gum disease?	YES NO
Do your gums ever bleed?	YES NO
Do you brush and floss on a routine basis? Discuss	YES NO
Do you feel nervous about having dental treatment?	YES NO
Have you ever had a bad experience in a dental office? Describe	YES NO
Do you want to keep your remaining teeth?	YES NO
Do you like your smile? Why?	YES NO
Name of previous dentist (optional)	

MEDICAL HISTORY

Medical doctor's name	
Are you under a doctor's care now? Why?	YES NO
Have you been hospitalized during the past two years? Why?	YES NO
Are you taking any medications, pills, or drugs? What?	YES NO
Are you allergic to any medications or substance? What?	YES NO
Are you pregnant? (women)	YES NO

PLEASE CHECK THE FOLLOWING:

	Yes	No
Heart Trouble	☐	☐
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Heart Murmur	☐	☐
Rheumatic Fever	☐	☐
Congenital Heart Lesion	☐	☐
Artificial Heart Valve	☐	☐
Heart Pacemaker	☐	☐
Heart Surgery	☐	☐
Blood Disease	☐	☐
Anemia	☐	☐

	Yes	No
Chest Pain	☐	☐
Shortness of Breath	☐	☐
Swelling of Feet/ Ankles/Hands	☐	☐
Fainting or Dizziness	☐	☐
Stroke	☐	☐
Diabetes	☐	☐
Excessive Thirst	☐	☐
Artificial Joints/Hips	☐	☐
Kidney Trouble	☐	☐
Ulcers	☐	☐
Allergies	☐	☐

	Yes	No
Scarlet Fever	☐	☐
Asthma	☐	☐
Hay Fever	☐	☐
Sinus Trouble	☐	☐
Emphysema	☐	☐
Frequent Cough	☐	☐
Lung Disease	☐	☐
Tuberculosis	☐	☐
Liver Disease	☐	☐
Hepatitis A (infec.)	☐	☐
Hepatitis B (serum)	☐	☐
Yellow Jaundice	☐	☐

	Yes	No
Cancer	☐	☐
Thyroid Disease	☐	☐
Abnormal Bleeding	☐	☐
Parathyroid Disease	☐	☐
X-ray or Cobalt Trmt.	☐	☐
Chemotherapy/Radiation	☐	☐
Arthritis/Gout	☐	☐
Rheumatism	☐	☐
Pain in Jaw Joints	☐	☐
Cortisone Medicine	☐	☐
Glaucoma	☐	☐
Epilepsy or Seizures	☐	☐
Nervousness	☐	☐

	Yes	No
Hypoglycemia	☐	☐
Psychiatric Care	☐	☐
Drug Addiction	☐	☐
Blood Transfusion	☐	☐
Hemophilia	☐	☐
AIDS	☐	☐
Venereal Disease	☐	☐
Cold Sores	☐	☐
Fever Blisters	☐	☐
Herpes	☐	☐
Bruise Easily	☐	☐
Sickle Cell Anemia	☐	☐
HIV	☐	☐

Have you ever had any other serious illness not circled above? ☐YES ☐ NO

Please describe in detail _____

Do you wish to talk to the doctor privately about any problem? ☐YES ☐ NO

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed by: Doctor _____ Date _____

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	B.P.	REVIEWED BY
		None ☐			DR.
		None ☐			DR.
		None ☐			DR.
		None ☐			DR.
		None ☐			DR.
		None ☐			DR.
		None ☐			DR.

ACCOUNT NUMBER

FORM NO. 202 (REV 1-84)

INITIAL DENTAL AND MEDICAL HISTORIES & UPDATES

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-Mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revision of our Notice, at any time by contacting:

Phone Number: 808-735-8883
Email: The Dental Corner Hawaii@gmail.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to thee Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

The Dental Corner/Tooth Surfer LLC

3045 Monsarrat Ave., Suite 7
Honolulu, HI 96815
(808)735-8883

By signing below, I indicate that I have read, understood and accept the following conditions related to my financial obligations:

1. Myself and/or the person I designated below are financially responsible for all the charges incurred.

2. The Dental Corner/Tooth Surfer LLC is authorized, if applicable, to bill my insurance for all charges incurred.

3. If I am unable to keep my appointment, I will give the office at least 24 hours notice. If appropriate notice is not given, this missed appointment will be considered a "NO-SHOW". After the second "NO-SHOW" a $50.00 fee will be assessed. In addition, after the second "NO-SHOW" or missed appointment the patient will be placed on the "Call List" for future appointments.

4. The Dental Corner/Tooth Surfer LLC will collect 10% of the total fee(not of the insurance co-pay) of a procedure as a scheduling deposit, before making any appointments of 90 minutes or greater. If I cancel or fail such an appointment without at least 24 hours notice, this deposit will be forfeited.

_____ _____

Patient Signature Date