kdc
kaua'i dental care

4400 Pahee Street
Lihue, HI 96766
Phone: 808.241.7464
Fax: 808.241.7469
Email: info@kauaidentalcare.com

Patient Information

Date _____

Patient First Name _____

Last Name _____Middle Initial ____

Wish to be called _____

Social Security # _____

Mailing Address _____

City _____ State _____ Zip _____

Physical Address _____

City _____ State _____ Zip _____

Date of Birth ___/___/___ Sex ☐ Male ☐ Female

Employer/School _____

Job Title _____

Has any member of your family ever been treated in our office? If yes, who? _____

How did you hear of our office?

☐ Another patient ☐ Physician/Dentist
☐ Website ☐ Radio
☐ Yellow Pages ☐ Newspaper

Whom may we thank for referring you?

_____

Dental Insurance

Responsible for this account?_____

Relationship to Patient _____

Date of Birth ___/___/___ SS# _____

Employer _____

Address _____

Work Phone # _____ Cell # _____

Primary Insurance Name: _____

Subscriber's Name _____

Social Security # _____

Date of Birth ___/___/___ Group # _____

Member/Subscriber # _____

Relationship to Patient _____

Secondary Insurance Name: _____

Subscriber's Name _____

Social Security # _____

Date of Birth ___/___/___ Group # _____

Member/Subscriber # _____

Relationship to Patient _____

Insurance Assignment & Release

I certify that I, and/or my dependent(s), have insurance coverage with the above-named company(ies) and assign directly to Kauai Dental Care all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. Kauai Dental Care may use my health care information and may disclose such information to the above-named company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits.

X _____ X_____ X_____

Signature of Patient, Parent, or Guardian | Print Name | Date

Phone Numbers & Emergency Contact

INCLUDE ALL PHONE NUMBERS/EMAIL AND ☑ CHECK OFF THE BEST WAYS TO REACH YOU:

☐ Home _____ ☐ Work _____ ☐ Cell _____ ☐ Email _____

IN CASE OF EMERGENCY CONTACT

Name _____ Relationship _____

Primary Phone # _____ Secondary Phone # _____

kdc
kaua'i dental care

4400 Pahee Street
Lihue, HI 96766
Phone: 808.241.7464
Fax: 808.241.7469
Email: info@kauaidentalcare.com

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

Dental History

Reason for today's visit _____

Previous Dentist's Name _____ Date of last dental visit _____

How often do you brush your teeth? _____ How often do you floss? _____

Have you ever had:			**Do you:**		
Orthodontic Treatment	☐ Yes	☐ No	Frequently get cold sores	☐ Yes	☐ No
Endodontic Treatment (Root Canals)	☐ Yes	☐ No	Clench/grind teeth while awake or asleep	☐ Yes	☐ No
Oral Surgery (Extractions)	☐ Yes	☐ No	Smoke/chew tobacco	☐ Yes	☐ No
Periodontal Treatment	☐ Yes	☐ No	Wear a bite plate or mouth guard	☐ Yes	☐ No
Your gums hurt or bleed	☐ Yes	☐ No			
Any mouth odor or bad taste	☐ Yes	☐ No	**Have you ever experienced:**		
Any loose teeth	☐ Yes	☐ No	TMJ/TMD (Temporomandibular Joint Disorder)	☐ Yes	☐ No
Food getting caught between your teeth	☐ Yes	☐ No	Occlusal equilibration / bite adjusted	☐ Yes	☐ No
If yes, where?			Clicking or popping of the jaw	☐ Yes	☐ No
			Pain (joint, ear, side, or face)	☐ Yes	☐ No
A serious injury to the mouth or head	☐ Yes	☐ No	Difficulty in opening or closing the mouth	☐ Yes	☐ No
If yes, please describe, including the cause:			Tired jaw muscles esp. in the morning	☐ Yes	☐ No
			Heartburn	☐ Yes	☐ No
			Are any of your teeth sensitive to:		
			Hot or cold	☐ Yes	☐ No
			Sweets	☐ Yes	☐ No
			Biting or chewing	☐ Yes	☐ No

Do you feel nervous about having dental treatment? ..... ☐ Yes ☐ No

Have you ever had an upsetting dental experience? ..... ☐ Yes ☐ No

Is there anything else about having dental treatment that you would like us to know? ..... ☐ Yes ☐ No

If **yes** to any of the above, please describe _____

_____

Do you like the appearance of your teeth? ..... ☐ Yes ☐ No

Is there anything you want to change? _____

_____

Are you interested in teeth whitening? ..... ☐ Yes ☐ No

kdc
kaua'i dental care

4400 Pahee Street
Lihue, HI 96766
Phone: 808.241.7464
Fax: 808.241.7469
Email: info@kauaidentalcare.com

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

Medical History

Have you been under the care of a medical doctor during the past two years? ..... ☐ Yes ☐ No
If yes, for what? _____
Physician's Name _____ Phone # _____

Allergies / Previous Adverse Reactions

☐ Aspirin	☐ Erythromycin	☐ Nitrous Oxide	☐ Tetracycline
☐ Codeine/Other Narcotics	☐ Iodine	☐ Penicillin	Other:
☐ Costume Jewelry	☐ Latex	☐ Sedatives/Tranquilizers	
☐ Dental Gloves	☐ Local Anesthetic	☐ Sulfa Drugs	

Do you or have you had:

Artificial Heart Valve	☐ Yes	☐ No	Heart Attack / Stroke	☐ Yes	☐ No	Hi/Lo Blood Pressure	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Congenital Heart Disease	☐ Yes	☐ No	Heart Pacemaker	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No

Have you had abnormal bleeding associated with a previous extraction, surgery, cut or trauma? If yes, explain:	☐ Yes	☐ No
Do you take, or have you ever taken, any medication for osteoporosis?	☐ Yes	☐ No
Are you taking anticoagulants (blood thinners, Coumadin, Aspirin) daily?	☐ Yes	☐ No
Have you or any family member had Tuberculosis (TB)?	☐ Yes	☐ No
Have you been in contact with anyone who has had Tuberculosis (TB)?	☐ Yes	☐ No
Have you had a productive (very deep) cough that has lasted more than 3 weeks? If yes, did you have: Fever ☐ Yes ☐ No Night Sweats ☐ Yes ☐ No Rapid Weight Loss ☐ Yes ☐ No General Malaise ☐ Yes ☐ No	☐ Yes	☐ No

Indicate which of the following you have had or have at present:

A.I.D.S.	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Neurological Disorders	☐ Yes	☐ No
Alcoholism/Drug Abuse	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Allergies or Hives	☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No	Psychological	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Rapid weight loss/gain	☐ Yes	☐ No
Arthritis/Rheumatism	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Radiation Therapy	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Hepatitis A (infectious)	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Hepatitis B (serum)	☐ Yes	☐ No	Stomach Disorders	☐ Yes	☐ No
Cortisone Medication	☐ Yes	☐ No	HIV Positive / Exposure	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No	Tumors/Cysts/Cancer	☐ Yes	☐ No
Diet (special/restricted)	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Eating Disorders	☐ Yes	☐ No	Nervousness/Anxiety	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ No

Are you taking any medication, drugs or pills now? If yes, please list name(s) and dosage(s):	☐ Yes	☐ No
Do you have, or have you had, any disease, condition or problem not listed? If yes, explain:	☐ Yes	☐ No
Have you been a patient in the hospital or had a serious illness during the past 5 years? If yes, explain:	☐ Yes	☐ No

Women, are you pregnant? ☐ Yes ____ Months ☐ No Nursing? ☐ Yes ☐ No 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 the questions to the best of my knowledge. I will notify the doctor of any change in my health or medication.

Patient/Parent/Guardian Signature _____ Date _____

Doctor Signature _____ Date _____

ACCOUNT NUMBER

| |

kdc
kaua'i dental care

4400 Pahee Street
Lihue, HI 96766
Phone: 808.241.7464
Fax: 808.241.7469
Email: info@kauaidentalcare.com

Appointment and Payment Policies

Kauai Dental Care is happy to take care of your dental needs. Please help us by following our appointment and payment policies.

BROKEN OR CANCELED APPOINTMENTS
If you need to cancel an appointment, please notify us at least 24 hours in advance for Tuesday through Thursday appointments and no later than 10 a.m. Thursday for Monday appointments. We charge $40-$50 for each canceled or broken appointment if you do not give us the required advanced notice. Please notify us if an emergency makes it impossible for you to give 24 hours notice so that we can discuss this with you. Please do not cancel an appointment with a voice mail message. Instead, please talk to us during office hours to avoid confusion. Our office hours are Monday through Thursday, 7:30 a.m. to 6:00 p.m.

PAYMENT IS DUE AT THE TIME OF TREATMENT
Estimated payment for treatment is due in full at the time of treatment, unless you have made other payment arrangement with us. If we are filing an insurance claim for you, please read the next section for an explanation of payment arrangements.

INSURANCE CLAIMS
If we file an insurance claim for you, you will need to pay us the expected insurance deductible and any amount that we expect your insurance will not cover at the time of treatment. We try to get accurate information about insurance benefits and coverage before treatment, but we cannot be sure what the insurance company will pay, if anything, until the claim is submitted and the insurance company actually pays on the claim. It is not unusual for insurance companies to give us erroneous information about coverage or benefits. This is important, because you are responsible for all treatment charges, whether or not your insurance company provides any benefits.

RETURNED CHECKS
Please take every precaution to avoid giving us a bad check. We charge $35.00 for any check that is returned to us without payment to cover the bank fees we are charged. If you have given us a bad check in the past, we will not accept a personal check from you in the future as payment for dental services.

INTEREST ON LATE PAYMENTS
Please pay your charges on time. We rely on prompt payment from our patients and their insurance companies. For charges not paid within 30 days, we will charge your account interest at the rate of 1½% per month. We recommend that you understand your insurance benefits and monitor your plan for prompt payment.

COLLECTION COSTS
We will charge your account for our collection costs if we refer your account to an outside agency or attorney for collection. These costs include the collection agency's commission and, if an account is collected after the start of a collection lawsuit, reasonable attorney's fees, expenses and court costs. For a referred account that is collected prior to the start of a collection lawsuit, we will add 43% to the principal amount due so that the office will be left with the full principal amount after deducting the collection agency's commission from the amount collected.

I agree to the above policies and charges.

X _____ Date signed: _____
Signature of patient or responsible person

_____ _____
Name of Patient (print) Name of responsible person if different