Patient Registration

Kalaheo Dental Group
KalaheoDental.com

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Welcome to Kalaheo Dental Group- *we want your visit to be pleasant and comfortable. Please help us to prepare to serve your treatment needs by completing these forms. If you need assistance, please don't hesitate to ask.*

How did you hear about our office OR whom may we thank for referring you?_____
Facebook___ Instagram___ Google___ Yelp___ Website___ Sign___ Other (specify)_____

Patient Name: _____**Preferred Name:** _____
First Middle Initial Last

Date of Birth: _____ SS#**(insurance purposes only):**_____ **Sex:**____Male ____Female

Status:_____Single _____Married _____Child _____Divorced _____ Widowed

Mailing Address: _____
Street/ PO Box City State Zip Code

Home Phone #:_____ **Cell #:** _____**Work#:** _____

E-mail: _____(We will not share your e-mail with any 3rd parties)

Preferred method of contact:(Please number in order of preference)____ Home ____Cell ____Work ____E-mail

Employer: _____ **Occupation:** _____

May we contact you at work?___YES ___NO

INSURANCE INFO:

Insurance Carrier: _____ Subscriber Name: _____ Subscriber DOB: _____

Subscriber ID#: _____ORSubscriber SS#: _____Relationship: _____
(Self, Spouse, Child)

RESPONSIBLE PARTY:(If not the patient)

Name: _____ Phone: _____ Relationship: _____

EMERGENCY CONTACT:

Name: _____Phone:_____ Relationship: _____

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KalaheoDental.com

Welcome to our practice! We are delighted that you trust us with your oral healthcare needs. Every day we strive to make your time with us as pleasant, comfortable and affordable as possible.

Our office policy regarding finances & dental insurance:

Please understand that;

If you have dental insurance coverage, whether you have purchased a private plan or your employer, spouse or other family member has provided it to you, it is the patient's responsibility to know and understand the coverage provided. As a courtesy to our insured patients, we submit the claims to your insurance company at no cost to you and we will do our best to help you receive the maximum allowable benefits. In order for us to do so, we will need your current insurance card and/or insurance policy information on your first visit of every insurance benefit year. Please note that your insurance benefit year may not necessarily run January to December.

Regardless of what we may calculate your insurance company to pay, it is only an ***estimate***. Our estimate is based on limited information provided to us by your dental insurance company. Unfortunately, we cannot always accurately forecast what they will cover.

Your dental insurance is not designed to pay the entire cost of your treatment, but it is intended to help cover a certain portion of the cost based on the coverage provided. A better term for dental insurance is "dental assistance" or "dental benefits".

The financial obligation for dental treatment provided is between the patient and our office, and not between our office and your dental insurance company. We must stress that it is the patient's responsibility for payment made in full. Unless, you have previously entered into a payment plan agreement with our office.

NOTE:<u>All of our doctors will diagnose treatment based on your dental health, NOT on your dental insurance coverage.</u>

Our cancellation & broken appointment policy:

In order for us to meet the needs of our patients, we reserve time in our schedule according to your preferences and the treatment planned for your appointment. Therefore, in consideration of other patients, we ask that you contact our office at least 2 business days prior to your appointment if you need to reschedule. This way we may have time to contact and accommodate others who wish to be seen during the time reserved for you. A $50 cancellation/broken appointment fee will be assessed should we not receive notice of your need to reschedule within 24 hours of your appointment.

Our deposit policy:

In order to reserve your appointment time scheduled for any treatment with the dentist or dental hygienist, you must make a deposit in advance during the time of booking. This prepayment will be applied toward your services and can be refunded if services are not rendered.

I have read and understand the information provided to me by Kalaheo Dental Group regarding the office policy for finances, dental insurance and cancelled or broken appointments. By signing below I am indicating my acceptance of these policies and for the mutual convenience of the practice and I, it is understood that this executed copy of the office policies shall also cover my dependent children, if they are patients of the practice. Mahalo!

_____	_____	_____
Patient Name (Print)	Patient/Guardian Signature	Date

Dental History & General Oral Health Info

Please answer the following questions to the best of your ability.

1. How can we help you today? _____
2. Are you currently in any pain? Explain,_____
3. How is your current dental health? _____ Good _____ Fair _____ Poor
4. Approximately, how many times do you: Brush per day? _____ Floss per week? _____
5. When was your last dental cleaning? _____
6. When was your last dental visit? What was done?_____
7. Are you using any oral appliances (denture, nightguard, etc.)?_____
8. Are your teeth sensitive to hot, cold or anything else? Explain,_____
9. **NO YES** Do your gums bleed?
10. **NO YES** Are you missing any teeth?
11. **NO YES** Have you ever had gum treatment?
12. **NO YES** Do you now or have you ever had any pain or discomfort in your jaw joint? (TMJ)

13. **NO YES** Do you like your smile?
14. **NO YES** Would you like to have whiter teeth?

Kalaheo Dental Group offers a wide variety of services to enhance and keep your smile beautiful. Please **circle** any services you would like our friendly staff to discuss with you during your visit.

Implants/Tooth Replacement	**Smile Makeover**	**Bonding**
Veneers/Lumineers	**GLO Whitening**	**Invisalign**

15. **NO YES**Is there anything you would like to change about your smile? Explain,_____

_____

16. **NO YES**Do we have permission to discuss treatment options to improve your smile and appearance?

17. **NO YES** Have you ever had any unfavorable dental experiences?
18. **NO YES** Have you ever had a serious or difficult problem with any previous dental work? Explain,_____

_____

19. How can we best accommodate you during your dental visit(s)? _____

_____

20. **NO YES** Have you been told to take antibiotics before dental treatment? Specify,_____

_____

Medical History & General Health Info

Certain conditions and medications may make it necessary for us to alter our advice regarding your treatment. Please assist us in delivering optimal care by providing the following information:

1. Are you currently taking any medications? If so, please list:_____

_____

2. Are you currently under the care of a physician? If so, please explain:_____

3. Have you ever been hospitalized? If so, please explain:_____

4. Do you use tobacco in any form? If so, for how long? _____

5. Do you snore? **YES** or **No** (circle one) Do you feel tired, fatigued or sleepy during the day? **YES** or **No** (circle one)

Do you have a history of:(PLEASE CIRCLE ONE, specify as needed.)

1. **NO YES** High or low blood pressure or heart problems? _____
2. **NO YES** Mitral valve prolapse or Rheumatic fever? _____
3. **NO YES** Pacemaker, open heart surgery, prosthetic heart valve implant? Stent? _____
4. **NO YES** Joint Replacement, blood transfusions, organ transplant? _____
5. **NO YES** Tuberculosis or lung problems? Persistent productive coughing? _____
6. **NO YES** Hepatitis, jaundice or liver disease? _____
7. **NO YES** Venereal disease or herpes? _____
8. **NO YES** Acquired Immune Deficiency Syndrome (Aids) or HIV? _____
9. **NO YES** IV drug use? _____
10. **NO YES** Bleeding or clotting disorder? _____
11. **NO YES** Diabetes, kidney, thyroid problems? _____
12. **NO YES** Ulcers, acid reflux or stomach problems? _____
13. **NO YES** Epilepsy or nervous disorder? _____
14. **NO YES** Asthma, hay fever, sinusitis or other allergies? _____
15. **NO YES** Cancer or tumors? Have you had radiation or chemo therapy? _____
16. **NO YES** Arthritis, fibromyalgia or connective tissue disorder? _____
17. **NO YES** Head, face or jaw trauma/ injury? _____
18. **NO YES** Do any wounds heal slowly or present complications? _____
19. **NO YES** History of taking Bisphosphonates? (Circle One: Fosamax, Zometa, Aredia, Actonel, Boniva, Reclast) Other:_____
20. **NO YES** Taking any blood thinners? (Aspirin, Plavix, Coumadin (Warfin), Pradaxa, Aggrenox, Eliquis, Xarelto) Other:_____
21. **NO YES** Sleep Apnea? Do you use a CPAP or Oral Sleep Appliance?_____

Allergies:(Circle YES or NO, specify.)

NO YES *Aspirin*
NO YES *Dental Anesthetics*
NO YES *Erythromycin*
NO YES *Penicillin*
NO YES *Codeine*
NO YES *Latex*
NO YES *Metals*
NO YES *Amoxicillin*
Other:

Females:(Circle YES or NO, specify.)

NO YES *Are you taking birth control?*

NO YES *Are you pregnant? If so, how many weeks?____ Due date: _____*

NO YES *Are you nursing?*

Is there any additional health information that we should know? _____

_____

I acknowledge that the information I've provided has been given correctly and that it is my responsibility to inform the office and my provider of any changes or updates in my medical history.

_____ _____

Patient Name Patient/Guardian Signature Date