WELCOME TO OUR PRACTICE

PATIENT INFORMATION

NAME: _____ AGE: ____ BIRTHDATE (MM/DD/YYYY):____/____/_____
LAST FIRST
SSN:_____-_____-_____ PRIMARY PHONE :_____ SECONDARY PHONE:_____
EMAIL:_____ SEX: M F WEIGHT: _____LBS
ADDRESS: _____
NUMBER STREET NAME CITY STATE ZIP
MARITAL STATUS: SINGLE MARRIED WIDOWED SEPARATED DIVORCED
SPOUSE NAME:_____ SPOUSE PHONE:_____

EMERGENCY CONTACT : NAME: _____ PHONE:_____RELATIONSHIP:_____

WHO MAY WE THANK YOU FOR REFERRING YOU? _____

PRIMARY INSURANCE INFORMATION

SUBSCRIBER NAME:_____ BIRTHDATE(MM/DD/YYYY):_____/_____/_____
INSURANCE COMPANY: _____ SUBSCRIBER # :_____
RELATIONSHIP: (SELF / SPOUSE / DEPENDENT)

SECONDARY INSURANCE INFORMATION

SUBSCRIBER NAME:_____ BIRTHDATE(MM/DD/YYYY):_____/_____/_____
INSURANCE COMPANY: _____ SUBSCRIBER # :_____
RELATIONSHIP: (SELF / SPOUSE / DEPENDENT)

CHIEF COMPLAINT

ARE YOU CURRENTLY IN PAIN ? YES / NO
DOES YOUR JAWS HURT? YES / NO
DO YOU HAVE HEADACHES, NECK PAIN, BACK PAIN, RINGING IN THE EARS,
TINGLING IN YOUR HANDS? YES / NO

MEDICAL HISTORY

MEDICAL DOCTOR'S NAME:_____ PHONE: (_____)_____
ARE YOU UNDER A DOCTOR'S CARE NOW ? WHY?_____
HAVE YOU BEEN HOSPITALIZED FOR THE PAST TWO YEARS?
WHY?_____ YES / NO
PLEASE LIST ANY MEDICATIONS, PILLS, DRUGS YOU ARE TAKING BELOW:
_____
_____
_____
_____

ARE YOU TAKING OR EVER TAKEN BISPHOSPHONATE SUCH AS FOSAMAX, ACTONEL, BONIVA? YES / NO

ARE YOU ALLERGIC TO ANY MEDICATIONS OR SUBSTANCE? WHAT? YES / NO

HAVE YOU EVER TAKEN PHEN-FEN OR REDUX? YES / NO

DO YOU HAVE ANY FORM OF IMPLANTS? IF YES PLEASE DESCRIBE. YES / NO

_____

WOMEN - ARE YOU OR COULD YOU BE PREGNANT?IF YES HOW MANY MONTHS?___ YES / NO

DO YOU DRINK ALCOHOL? IF SO, HOW OFTEN? _____ YES / NO

DO YOU USE TOBACCO PRODUCTS? IF SO, HOW OFTEN? _____ YES / NO

MEDICAL CONDITIONS(please check if you have any of the following)

- ☐ ABNORMAL BLEEDING
- ☐ ALLERGIES
- ☐ ANEMIA
- ☐ ARTIFICIAL HEART VALVE
- ☐ ARTIFICIAL JOINTS
- ☐ ASTHMA
- ☐ BLOOD DISEASE
- ☐ BLOOD TRANSFUSION
- ☐ BONE INFECTION
- ☐ CANCER
- ☐ CHEMOTHERAPY/ RADIATION
- ☐ CHEST PAIN
- ☐ CONGENITAL HEART LESION
- ☐ COSMETIC SURGERY
- ☐ DIABETES
- ☐ DRUG ADDICTION
- ☐ EMPHYSEMA
- ☐ EPILEPSY OR SEIZURES
- ☐ FAINTING OR DIZZINESS
- ☐ FREQUENT COUGH
- ☐ GLAUCOMA
- ☐ GOUT
- ☐ HEART DISEASE
- ☐ HEART MURMUR
- ☐ HEART PACEMAKER
- ☐ HEART SURGERY
- ☐ HEPATITIS A (INFECTION)
- ☐ HEPATITIS B
- ☐ HERPES
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ HIV/AIDS
- ☐ KIDNEY TROUBLE
- ☐ LIVER DISEASE
- ☐ LOW BLOOD PRESSURE
- ☐ LUNG DISEASE
- ☐ OSTEOPOROSIS
- ☐ PSYCHIATRIC CARE
- ☐ RHEUMATOID ARTHRITIS
- ☐ RHEUMATIC FEVER
- ☐ SINUS TROUBLE
- ☐ STOMACH PROBLEM/ ULCER
- ☐ STROKE
- ☐ SWELLING OF FEET/ANKLES
- ☐ THYROID PROBLEM/ DISEASE
- ☐ VENEREAL DISEASE

HAVE YOU EVER HAD ANY SERIOUS ILLNESS NOT CHECKED ABOVE? _____

PLEASE DESCRIBE IN DETAIL:

_____

_____

_____

_____

_____

_____

AUTHORIZATION

I hereby grant permission to the dentist to perform all procedures and diagnostic tests which he deems necessary. THESE ACCEPTED PROCEDURES MAY INCLUDE X-RAYS, PICTURES (WHICH MAY BE USED FOR MARKETING AND / OR FOR OUR GALLERY), administration of medications, local anesthetics (complications in rare case might be prolonged numbness which sometimes might be indefinite), dental prophylaxis, dental restorations, and dental surgical procedures. If the patient is a minor, I, as a parent/legal guardian, give consent to the dentist to perform any necessary dental treatment to my child whether I am present or not in the clinic.

PATIENT SIGNATURE:_____ **DATE:** _____

PARENT OR GUARDIAN: _____**RELATIONSHIP:**_____ **DATE:** _____

GENERAL DENTAL RESPONSIBILITY, CONSENT AND RELEASE STATEMENT

I authorize my insurance company to pay Dr. Aaron Colby all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payments of the benefits. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE. I ALSO UNDERSTAND THAT THE TREATMENT ESTIMATE PRESENTED TO ME IS ONLY AN ESTIMATE. OCCASIONALLY, THE NEED MAY ARISE TO MODIFY TREATMENT. IN SUCH A CASE, I WILL BE INFORMED OF THE NEED FOR ADDITIONAL TREATMENT, AND ITS FEE MODIFICATION. I understand that there will be a $25 fee for a returned check. If I become delinquent in my account, I authorize this office to send me to a collection agency. If a collection agency services are required, I further agree to pay all legal fees and cost incurred in connection therewith. Service charges not paid when due shall be added to and become part of the principal and bear like interest until paid. I also understand that in order to collect my debt, my credit history may be checked through the use of my social security number or any other information I have given you.

I HAVE READ, UNDERSTAND, AND BEEN OFFERED A COPY OF THE OFFICE POLICY FOR PRIVACY PRACTICES (HIPAA). I AUTHORIZE PERIODONTICS HAWAII TO LEAVE MESSAGES ON MY VOICEMAIL/ CELL PHONE TO CONFIRM MY APPOINTMENT.

TO THE BEST OF MY KNOWLEDGE THE INFORMATION IN THIS FORM IS ACCURATE

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. 24HRS (EXCLUDING SUNDAYS AND HOLIDAYS) NOTICE MUST BE GIVEN FOR ALL APPOINTMENT CANCELLATIONS OR YOU WILL BE CHARGED A $50 CANCELLATION FEE.

PATIENT SIGNATURE_____ **DATE**_____

PARENT OR GUARDIAN_____ **DATE**_____

REVIEWED BY DR._____ **DATE**_____