New Patient Form (Child)

PATIENT INFORMATION

Patient's Name_____ Sex ☐M ☐F
(Last / First / MI)

Address_____
(Street / City / State / Zip)

Home Phone_____ Birthdate_____ School_____

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

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

Which method(s) would you prefer to receive notifications of your future appointments? *Check all that apply*

☐ Email_____ ☐ Text Messaging_____ ☐ None

RESPONSIBLE PARTY INFORMATION *(Person financially responsible for making payment)*

Name_____ Marital Status_____
(Last / First / MI)

Residence_____ ☐ Own ☐ Rent
(Street / City / State / Zip)

Mailing Address_____
(Street / City / State / Zip)

How long at this address?_____ Home Phone_____ Work Phone_____ Cell_____

Previous Address (if less than 3 yrs.)_____
(Street / City / State / Zip)

Social Security# *(optional)* #_____ Birthdate_____ Relationship to patient_____

Employer_____ Occupation/Military Rank_____ No. Years Employed_____

Responsible Party's Email Address_____

How would you prefer to receive your statements? ☐ Email ☐ Mail

Spouse's Name_____ Relationship to patient_____
(Last / First / MI)

Social Security #_____ Birthdate_____ Email_____

Employer_____ Occupation/Military Rank_____ No. Years Employed_____

Spouse's Email Address_____ Home Phone_____ Cell _____

DENTAL INSURANCE *(Please provide Dental Insurance Card upon visit.)*

Policy Holder's Name_____ Insured's Soc. Sec. #_____

Insurance Company_____ Group No._____ Local No._____

Do you have dual Coverage? Yes ☐ No ☐ If YES:

Policy Holder's_____ Insured's Soc. Sec. #_____

Insurance Company_____ Group No._____ Local No._____

IN CASE OF AN EMERGENCY, please provide the name of nearest relative not living with you:

Name_____ Relationship to Patient _____

Home_____ Work_____ Cell_____

I understand that where appropriate, credit rating may be obtained.

Signature ***(****Parent or Guardian's signature if minor)*_____ Date_____

Hawaiian Smiles ORTHODONTICS

45-939 Kamehameha Hwy., Suite 103
Kaneohe, HI 96744
(808) 247-6039

76-6225 Kuakini Hwy., D-101
Kailua-Kona, HI 96740
(808) 329-7551

65-1230 Mamalahoa Hwy., Suite A21
Kamuela, HI 96743
(808) 329-7551

MEDICAL/DENTAL HISTORY

Physician's Name: _____ Phone _____

Dentist's Name: _____ Phone _____

Date of Last Dental Cleaning: _____

☐ Yes ☐ No Is patient adopted?

☐ Yes ☐ No Are you currently under any medical treatment? _____

☐ Yes ☐ No Are you currently taking any medication? List: _____

☐ Yes ☐ No Do you have allergies? (Sulphur, penicillin, novocaine, etc.) _____

☐ Yes ☐ No Do you have difficulty breathing through the nose? _____

☐ Yes ☐ No Have you had your tonsils and/or adenoids removed? _____

☐ Yes ☐ No Do you have pain, clicking, and/or popping noises in the jaw? _____

☐ Yes ☐ No Are you aware of either clenching or grinding of teeth? _____

☐ Yes ☐ No Do you have frequent headaches? How often? _____

☐ Yes ☐ No Do you have ear problems? (Aches, ringing, dizziness, fullness) _____

☐ Yes ☐ No Do you have habits such as nail biting, finger or thumbsucking, lip or cheek biting? _____

☐ Yes ☐ No Do you have speech problems, or are you in speech therapy? _____

☐ Yes ☐ No Have you had your tonsils and/or adenoids removed? _____

☐ Yes ☐ No Has there been any history of: ☐ Joint Swelling ☐ Asthma ☐ TB ☐ Aids ☐ Kidney ☐ Liver Condition ☐ Epilepsy ☐ Rheumatic Fever ☐ Other major illnesses? _____

☐ Yes ☐ No Do you bleed easily? _____

☐ Yes ☐ No Is there a tendency to faint or become dizzy? _____

☐ Yes ☐ No Do you have a heart condition? ☐ Yes ☐ No

Do you pre-medicate? ☐ Yes ☐ No Name of Cardiologist: _____ _____

☐ Yes ☐ No Have there been any injuries to the teeth? _____

☐ Yes ☐ No Have you had any permanent teeth extracted? _____

☐ Yes ☐ No Have we treated any other family members? ☐ Yes ☐ No Who? _____

_____

Hawaiian Smiles
ORTHODONTICS

Pediatric Sleep Questionnaire
(Screening)

Today's Date: _____

Name of Child: _____ Date of Birth: _____

Person completing this form: _____ Relationship to Child: _____

Instruction: Please answer the questions about how your child **IN THE PAST MONTH**. Check the correct response or input your answers in the space provided. "Y" means "*Yes*," "N" means "*N*o," and "*DK*" means "Don't Know." For this questionnaire, the word "usually" means "more than half the time" or "on more than half the nights."

Please answer the following questions as they pertain to your child **in the past month**.

		YES	NO	Don't Know
1.	**While sleeping, does your child:**			
	Snore more than half the time?	☐	☐	☐
	Always snore?	☐	☐	☐
	Snore loudly?	☐	☐	☐
	Have "heavy" or loud breathing?	☐	☐	☐
	Have trouble breathing, or struggles to breathe?	☐	☐	☐
2.	**Have you ever seen your child stop breathing during the night?**	☐	☐	☐
3.	**Does your child:**			
	Tend to breathe through the mouth during the day?	☐	☐	☐
	Have a dry mouth on waking up in the morning?	☐	☐	☐
	Occasionally wet the bed?	☐	☐	☐
	Wake up feeling unrefreshed in the morning?	☐	☐	☐
	Have a problem with sleepiness during the day?	☐	☐	☐
4.	**Has a teacher or supervisor commented that your child appears sleepy during the day?**	☐	☐	☐
5.	**Is it hard to wake your child up in the morning?**	☐	☐	☐
6.	**Does your child wake up with headaches in the morning?**	☐	☐	☐
7.	**Did your child stop growing at a normal rate at any time since birth?**	☐	☐	☐
8.	**Is your child overweight?**	☐	☐	☐
9.	**This child often:**			
	Does not seem to listen when spoken to directly.	☐	☐	☐
	Has difficulty organizing tasks and activities.	☐	☐	☐
	Is easily distracted by extraneous stimuli.	☐	☐	☐
	Fidgets with hands or feet, or squirms in seat.	☐	☐	☐
	Is "on the go" or often acts if "driven by a motor."	☐	☐	☐
	Interrupts or intrudes on others (eg. butts in conversations or games).	☐	☐	☐

HAWAIIAN SMILES ORTHODONTICS- For Office Use Only: Total Count – YES_____

Hawaiian Smiles Orthodontics
NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 1, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider proving treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducing training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of the health of safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $25.00 for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use of disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location your request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: **Sue McLafferty** Telephone: **808.247.6039** Fax: **808.247.3643** Email: **Sue@HawaiianSmilesOrtho.com**
Address: 45-939 Kamehameha Highway, Suite 103, Kaneohe, Hawaii 96744

Hawaiian Smiles
ORTHODONTICS

Notice of Privacy Practices Acknowledgement (HIPPA)

I understand that, under the Health Insurance Portability and Accountability Act of 1996 "HIPPA", I have certain Rights to privacy regarding my protected health information, I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly or indirectly
- Obtain payment from third-party payers (Insurance carriers, etc.)
- Conduct normal healthcare operations

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosure of my health information. I understand that this practice has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this practice at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I am a request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you were bound to abide by such restrictions.

Patient Name	Name of Guardian (if Minor)	Relation to Patient

Patient Signature (Requires Guardian's signature if patient is a minor)	Date

Official Use Only

I've attempted to obtain the parents signature and acknowledgment of notice of privacy practices, but was an able to do so as documented below.

Print Name of Employee	Date

◊ Individual refused to sign
◊ Communication barriers prohibited obtaining the acknowledgement
◊ An emergency situation prevented us from obtaining acknowledgment
◊ Other (please specify) _____
_____

(2/2021)

Hawaiian Smiles
ORTHODONTICS

Your Orthodontic Appointments

Patient's Name: _____
Last First MI

In order to ensure quality orthodontic care, it is important that both parents and patients understand the manner in which we schedule your appointments. Our goal is to be the best part of your day and we make it a priority to value both you and your time. Therefore, we make every effort to stay on or ahead of schedule. Inconveniencing your work schedule and/or interrupting your child's studies as infrequently as possible is very important to our entire office. Since the vast majority of our patients are of school age, it is unavoidable that some school-time appointments will be necessary.

We are glad to work around your work schedule and/or child's important classes and provide your child with school excuses for scheduled orthodontic appointments.

Our staff works hard to provide the finest orthodontic care using the most convenient scheduling system possible for our parents and/or patients. Because we have families of our own, we understand your scheduling concerns and will do everything we can to ensure your treatment or child's treatment goes as smoothly as possible.

- **LONG APPOINTMENTS, BANDING, AND BONDING**: These are more detailed and technique-sensitive appointments. Therefore, these appointments will be scheduled during our quieter morning hours.

- **EMERGENCIES**: (Pain, swelling, or bleeding) This usually results from trauma to the face or mouth. These patients will be seen as soon as possible and either appropriate care given or referral to another specialist provided for treatment.

- **REPAIRS**: (Loose bands or brackets, broken arch wires or ties, broken appliances or retainers) These appointments are always scheduled specifically during school hours since they are long visits. The vast majority of your appointments over the course of treatment will be short appointments. By seeing our long-visit patients during school hours, it leaves more room in our schedule to see patients during after-school hours.

- **APPOINTMENTS BROKEN OR NOT CANCELLED WITHIN 48 HOURS**: Another appointment will be scheduled but may require waiting four to six weeks. An appointment made during morning hours may be arranged sooner.

- **GENERAL DENTIST APPOINTMENTS**: As treatment progresses, it is important to continue seeing your regular dentist every six months for a checkup and cleaning. Please let us know when you schedule your next dental appointment as we will schedule coordinating appointments to temporarily remove your wires before the visit. Immediately after your dental visit, we will replace your wires to ensure progressive tooth movement.

Thank you so very much for understanding.

I have read and agree to the scheduling information above:

Patient/Parent signature: _____ Date: _____

45-939 Kamehameha Hwy. Suite 103 ▪ Kaneohe, HI 96744 ▪ Phone (808) 247-6039 ▪ Fax (808) 247-3643
76-6225 Kuakini Hwy. D-101 ▪ Kailua Kona, HI 96740 ▪ Phone (808) 329-7551 ▪ Fax (808) 329-6924
65-1230 Mamalahoa Hwy, Suite A21 ▪ Kamuela, HI 96743 ▪ Phone (808) 225-1463