NEW PATIENT FORM (CHILD)

PATIENT INFORMATION

*Patient First Name:		*Last Name:		*Sex: ☐Male ☐Female			
*Address:		*City:		*State:		*Zip Code:	
*Date of Birth:		*Cell #		*Home #		*School:	
*Whom may we thank for referring you to our office?							
*Email Address:		*Text Message:					

***For communication purposes, please check box that applies:**

☐ I consent to receive electronic notifications, appointment reminders, statements, etc. (via text or email) from Hawaiian Smiles Orthodontics or their representatives. I acknowledge that there may be additional fees for texts from my individual cellular or network provider.

☐ **I DO NOT want to receive electronic notifications.** By removing yourself from electronic notifications, you may miss appointment reminders, documents, or payments which may result in a fee applied to your account.

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

RP#1 - *First Name:		*Last Name:		*Date of Birth:			
*Resident Address:				*State:		*Zip Code:	
*Mailing Address:				*State:		*Zip Code:	
*How long have you resided at this address?		*Do your rent or own your home? ☐ Rent ☐ Own					
If you lived there less than one year, what was your previous address?							
*Relationship to Patient:		*Marital Status:		*Email:			
*Employer:		*Occupation/Military Rank:		*# Yrs Employed:			

*As the main Responsible Party **(RP#1)**, you will receive your monthly statements via e-mail unless requested otherwise.*

RP#2 - First Name:		Last Name:		Date of Birth:			
Mailing Address:				State:		Zip Code:	
Relationship to Patient:		Relationship to RP#1:		Email:			
Employer:		Occupation/Military Rank:		# Yrs Employed:			

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

If you have MetLife or United Concordia insurance, please fill in your Social Security Number as the Subscriber number.

Policy Holder's Name:		Subscriber # / SSN		Date of Birth:	
Insurance Company:		Group #		Local #	

Do you have dual dental coverage? ☐Yes ☐No If YES:

Policy Holder's Name:		Subscriber # / SSN		Date of Birth:	
Insurance Company:		Group #		Local #	

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

*Name:		*Relationship to Patient:	
*Cell Phone:		Home Phone:	

By signing below, I indicate that I understand that where appropriate, credit rating may be obtained. I also hereby authorize and directly assign all insurance benefits, if any, otherwise payable to me to Hawaiian Smiles Orthodontics for services rendered. I hereby authorize the provider and/or their representatives to release any and all information necessary to secure the payments of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

*Signature:		*Date:	

*Mandatory field required (03/2023)

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) 247-6039

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? List:

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

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

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

*☐Yes ☐No Have you had your tonsils and/or adenoids removed? List:

*☐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, etc.)

*☐Yes ☐No Do you have habits such as nail biting, finger/thumb sucking, lip or cheek biting?

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

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

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

*☐Yes ☐No Do you bleed easily?

*☐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 have a heart condition?

*☐Yes ☐No Do you pre-medicate? ☐Yes ☐No

Name of Cardiologist? List:

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

*☐Yes ☐No Have we treated any other family members? Please list names:

*Mandatory field required

Pediatric Sleep Questionnaire

(Screening)

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 "*No*," 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

YOUR ORTHODONTIC APPOINTMENTS

Patient's First and Last Name:* _____

We realize that most people seeking orthodontic treatment have important obligations during the day. During active treatment, most patients are seen every 8 to 12 weeks. Our goal is to have as few of these appointments conflict with work or school as possible. We have put much effort and time into designing our scheduling system. Here is what we want to do: We want to see you on time for your appointments and to have plenty of time during each appointment to do the necessary treatments, give you information about your treatment and answer any questions. We also want to work with you around your school and work hours as much as possible. Thus, we need both structure and flexibility in the schedule. We understand your scheduling concerns and will do everything we can to ensure your treatment or child's treatment goes as smoothly as possible.

- **LONGER APPOINTMENTS:** There will be a few longer appointments during your treatment. These detailed and technique-sensitive appointments will be scheduled in our **Kaneohe** and **Kona** locations during school/work hours which allows us to accommodate as many families as possible for after-school/work appointments.

- **SHORTER APPOINTMENTS:** Due to technical advancements, many orthodontic appointments are blissfully short. Since these appointments do not require a lot of time, they can be done in all of our full-service offices.

- **EMERGENCIES**: (Pain, swelling, or bleeding) this usually results from trauma to the face or mouth. Please understand that although we try to keep a variety of emergency times available, we may not be able to offer you your "ideal" time for an emergency appointment. If you are having an orthodontic emergency and are in pain and it is after hours or on the weekend, please text or call our island specific emergency assistant on OAHU: (507) 401-6811 or BIG ISLAND:(808)987-5823. No scheduling requests will be taken on this emergency line. NOTE: We are closed Saturday and Sunday and most major Holidays

- **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**: **A $50 fee for each Broken/Missed/Cancelled appointment within the 48-hour window of your scheduled appointment will be charged.** Scheduling another appointment may require waiting four to six weeks which may lengthen your treatment time. Repeat cancellations or missed appointments will result in loss of future appointment privileges. We understand there will be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you experience such extenuating circumstances, please call or text our office so we can discuss your situation and disregard the no-show or late cancellation occurrence.

- **EXCESSIVE RESCHEDULING or CANCELLATIONS**: Excessive rescheduling or canceling your maintenance appointments may lengthen your treatment time. Should your treatment go past 6 months of your estimated treatment time based on excessive rescheduling or cancellations, Dr. Nayak will evaluate and charge additional monthly fees to complete your treatment.

- **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.

I have read and agree to the scheduling information above:

Patient/Parent Signature:* _____ Date:* _____

(03/2023) *Mandatory field required

Hawaiian Smiles
ORTHODONTICS

SOCIAL MEDIA RELEASE FORM

I consent to the use of my personal image and likeness, including but not limited to images representing and depicting the treatment provided to me and the effect thereof by Hawaiian Smiles Orthodontics for any lawful use where Hawaiian Smiles Orthodontics deems appropriate, including treatment, advertising his/her/its services to the general public (including via social media and electronic media), illustration, and publication to the public at large for education purposes. I hereby relinquish any and all rights to my likeness or any image of me/my child obtained by any photographic or digital means by Hawaiian Smiles Orthodontics during the course of my/my child's treatment. I understand that I am entitled to no consideration, remuneration, or payment for the use of my image in any advertising, promotional or education materials.

I understand any image or likeness of me may be altered prior to use if deemed appropriate by Hawaiian Smiles Orthodontics. I understand and agree that I have no right to be consulted about or approve of such alterations before my image used. I understand that Hawaiian Smiles Orthodontics will make all reasonable efforts to safeguard my privacy as required by applicable law, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand, however, that Hawaiian Smiles Orthodontics cannot guarantee my complete privacy in the event my image or likeness is used by third parties.

I understand and agree that Hawaiian Smiles Orthodontics may use information regarding my health condition, including information regarding my diagnosis, course of treatment, my date of birth and/or age, and my other relevant medical conditions, in describing the treatment rendered to me as depicted in any image of me.

I understand that Hawaiian Smiles Orthodontics may not and has not conditioned the rendition of treatment to me/my child upon my authorization of the use of my image and/or likeness.

I have read the preceding in its entirety and understand its terms.

Check box below if you choose to OPT OUT:

☐ I DECLINE from having myself/my child photographed and/or videotaped for social media, marketing or educational purposes.

*Name of Patient: _____

Printed Name of Parent, Legal Guardian or Authorized Representative (if patient is a Minor):

_____

*Signature of Patient / Parent, Legal Guardian or Authorized Representative (if patient is a Minor):

_____ *Date: _____

*Mandatory field required

HAWAIIAN SMILES ORTHODONTICS
NOTICE OF PRIVACY PRACTICES

This notice describes how medical 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.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Patients' Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Please submit your request in writing to the address listed at the end of this notice.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee and/or shipping and handling costs.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Please submit a written request to the address listed at the end of this notice. Please include the reason why the information should be amended. We may deny your request under certain circumstances and/or if it is against the law or is considered to be fraud, waste or abuse. If we say "no" to your request, we'll tell you why in writing within 60 days of our decision.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home, mobile or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests, however, your requests must include and specify in writing, the alternative means or location along with a satisfactory explanation how payments will be handled under the alternative means or location in your request.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting our Privacy Official listed at the end of this Notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice will be in effect as of May 1, 2023.

The Privacy Officer is Janine Otani, Financial Coordinator, and she can be reached by phone at (808) 247-6039, Fax at (808) 247-3643 or by email at janine@hawaiiansmilesortho.com. Please note we will never market or sell personal information.

Hawaiian Smiles
ORTHODONTICS

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), 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 disclosures 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 may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:*

Name of Parent/Guardian:
(if Patient is a Minor)

Relationship to Patient:

Patient / Parent / Guardian Signature:*

Date:*

Requires Parent/Guardian's signature if patient is a Minor

For Office Use Only

I attempted to obtain the patient's (guardian's) signature in acknowledgement of the *Notice of Privacy Practices*, but was unable to do so as documented below.

Print Name

Date

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

(03/2023)