# NEW PATIENT FORM (ADULT)

## PATIENT INFORMATION

| *Patient First & Last Name: | | *Sex: ☐Male ☐Female ☐Non-binary | | | |
|---|---|---|---|---|---|
| *Address: | | *City: | | *State: | *Zip Code: |
| *Date of Birth: | | *Cell # | | *Home # | |
| *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: | |

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

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

**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

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

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 (05/2023)

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: ______________

Why are you seeking Orthodontic Treatment? (check all that apply)

☐ I want to straighten my teeth ☐ I want to resolve my pain ☐ I have a special occasion coming up
☐ I want to correct my bite ☐ I want to improve my confidence

*☐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?

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