NEW PATIENT FORM (CHILD)

PATIENT INFORMATION

*Patient First & Last Name:						*Sex: ☐Male	☐Female	☐Non-binary	
*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:				

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)

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: _____

Why are you seeking Orthodontic Treatment for your child? (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