Hawaiian Smiles
ORTHODONTICS

NEW PATIENT FORM (ADULT)

Dr. Satya Nayak | Phone (808) 247-6039 | Fax (808) 247-3643
Kaneohe: 45-939 Kamehameha Hwy, Suite 103 | Kona: 76-6225 Kuakini Hwy, D-101
Waimea: 65-1230 Hawai'i Belt Rd, A21 | Hilo: 280 Ponahawai St, #101

** Mandatory field required ☐ = checkbox*

PATIENT INFORMATION

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

***Preferred Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Other: _____**

***Address:** ***City:** ***State:** ***Zip Code:**

***Date of Birth:** ***Cell #:** ***Home #:**

***How did you hear about us / Who referred you to our office?**

***Email Address:** ***Best number to receive text messages:**

***Communication Preference — please select one:**
☐ I consent to receive appointment reminders, statements, and updates via text or email. I understand standard carrier rates may apply for text messages.
☐ I do **not** wish to receive electronic communications. I understand I may miss appointment reminders and important documents.

RESPONSIBLE PARTY INFORMATION *(Person(s) financially responsible for this account)*

RP#1 — Primary Responsible Party *(will receive monthly statements by email unless otherwise requested)*

***First Name:** ***Last Name:** ***Date of Birth:**

***Resident Address:** ***State:** ***Zip Code:**

***Mailing Address (if different):** ***State:** ***Zip Code:**

***How long at this address?** ***Do you rent or own your home? ☐ Rent ☐ Own**

If less than one year — previous address:

***Relationship to Patient:** ***Marital Status:** ***Email:**

***Employer:** ***Occupation / Military Rank:** ***Years Employed:**

RP#2 — Secondary Responsible Party *(optional)*

First Name: **Last Name:** **Date of Birth:**

Mailing Address: **State:** **Zip Code:**

Relationship to Patient: **Relationship to RP#1:** **Email:**

Employer: **Occupation / Military Rank:** **Phone Number:**

IN CASE OF AN EMERGENCY — Nearest relative not living with you:

***Name:** ***Relationship to Patient:**

***Cell Phone:** **Home Phone:**

DENTAL INSURANCE

(Please bring your Dental Insurance Card to your appointment, or to make things easier, TEXT a photo of your insurance card to **(808) 247-6039***.)*

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

Primary Policy Holder's Name: **Subscriber # / SSN:** **Date of Birth:**

Insurance Company: **Group #:** **Local #:**

Do you have dual (secondary) dental coverage? ☐ Yes ☐ No

Secondary Policy Holder's Name: **Subscriber # / SSN:** **Date of Birth:**

Insurance Company: **Group #:** **Local #:**

Insurance Authorization & Signature

By signing below, I authorize Hawaiian Smiles Orthodontics to: (1) verify my credit and obtain necessary financial information; (2) receive and apply any insurance benefits directly to my account for services rendered; and (3) release information required to process insurance claims. This authorization applies to all insurance submissions on my behalf.

***Signature:** ***Date:**

ADULT MEDICAL / DENTAL HISTORY

Physician's Name: **Phone:**

Dentist's Name: **Phone:**

Date of Last Dental Cleaning: **Preferred Language:**

Why are you seeking orthodontic treatment? *(Check all that apply)*

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

Have you seen an orthodontist before?

☐ No, this is my first time seeing an orthodontist
☐ Yes, I have had previous orthodontic treatment
☐ Yes, I am seeking a second opinion

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

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

☐ Yes ☐ No Do you have any known allergies?
☐ Sulfa drugs ☐ Penicillin ☐ Local anesthetics (e.g., lidocaine) ☐ Latex ☐ Other: _____
Details: _____

☐ **Yes** ☐ **No** ☐ **N/A** **Are you currently pregnant or is there a possibility you could be pregnant?**
Please notify our team before any X-rays are taken.

☐ Yes ☐ No Do you experience pain, clicking, or popping in your jaw?

☐ Yes ☐ No Do you have habits such as nail biting, thumb sucking, or cheek biting?
Details: _____

☐ Yes ☐ No Have there been any injuries to your teeth or jaw?

☐ Yes ☐ No Have we treated other family members?
Details: _____

☐ Yes ☐ No Do you have a history of any of the following?
☐ Asthma ☐ Epilepsy ☐ TB ☐ AIDS/HIV ☐ Kidney or Liver Condition ☐ Joint Swelling
☐ Rheumatic Fever ☐ Heart Condition/Pacemaker ☐ Osteoporosis ☐ Other major illness: _____

☐ **Yes** ☐ **No** **Are you taking bisphosphonate medications for osteoporosis?**
(e.g., Fosamax, Boniva, Prolia, Reclast) — This is important for orthodontic treatment planning.

Do you snore, or have you been informed by a partner, family member, or roommate that you snore during sleep?
(Snoring may indicate airway concerns that can be relevant to orthodontic treatment planning.)

☐ Yes ☐ No

Level of dental anxiety: ☐ None ☐ Mild ☐ Moderate ☐ Severe

Hobbies / sports / activities (important for mouthguard recommendations):

Treatment Preferences

How important are clear aligners (Invisalign) to you? ☐ Very Important ☐ Somewhat ☐ Not Important
How important are traditional braces to you? ☐ Very Important ☐ Somewhat ☐ Not Important
How important is a low down payment? ☐ Very Important ☐ Somewhat ☐ Not Important
How important is a low monthly payment? ☐ Very Important ☐ Somewhat ☐ Not Important

Communication Style Preference

When it comes to understanding your orthodontic treatment, which best describes you? *(Please select one)*

☐ **Big picture —** I trust my orthodontist's expertise and mainly want to understand the overall treatment timeline and what it will cost. I do not need step-by-step details and am comfortable letting the doctor guide the process.

☐ **Full details —** I like to be fully informed and prefer a thorough explanation of each phase of my treatment, including how specific procedures work, why certain steps are taken, and what to expect throughout the process.

** Mandatory field required (Updated 2025)*

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Hawaiian Smiles Orthodontics

New Patient Appointment Policy

At Hawaiian Smiles Orthodontics, we value your time and are committed to a smooth, on-time experience for all of our patients. We send appointment reminders via email and text **7 days** and **3 days** before your scheduled visit. Reply **YES** to confirm or **NO** to reschedule.

Please Note:
If we do not receive a response from you within **48 hours** of your scheduled new patient appointment, your appointment may be **cancelled** after multiple unsuccessful attempts to reach you via email, text, and/or phone call. We encourage you to confirm or reschedule as soon as possible to keep your appointment time reserved.

First Consultation — Rescheduling Policy

More than 48 hours' notice:

- 1st reschedule — No charge.
- 2nd reschedule — A non-refundable $150 deposit is required to reschedule. This deposit will be credited toward your future treatment cost.
- 3rd reschedule — The deposit is forfeited. All future consultations will be conducted virtually only.

Less than 48 hours' notice (or no-show):

- 1st occurrence — A non-refundable $150 deposit is required to reschedule.
- 2nd missed appointment — The deposit is forfeited. All future consultations will be conducted virtually only.

Signature: **Date:**

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YOUR ORTHODONTIC APPOINTMENTS

***Patient's First and Last Name:**

During active orthodontic treatment, most patients are seen every **8 to 12 weeks**. We schedule most visits during after-work and after-school hours to reduce disruption to your day. A few visits during treatment may require longer appointment times.

- **LONGER APPOINTMENTS**: Some procedures require more time and are scheduled during daytime hours at our Kaneohe and Kona locations, keeping after-work slots available for routine visits.

- **SHORTER APPOINTMENTS**: Most visits are brief and can be completed at any of our full-service locations.

- **LATE ARRIVALS**: If you arrive 15 or more minutes late, your appointment may need to be rescheduled in order to accommodate other patients who arrived on time. If we are able to see you, please be aware that not everything originally planned for that visit may be completed.

- **ORTHODONTIC EMERGENCIES** (pain, swelling, or bleeding from trauma): After hours or on weekends, please **TEXT or send a picture message to (808) 247-6039**. You will be directed to the appropriate contact for your office location. **No scheduling requests will be taken on this line.** Note: Our office is closed Saturday, Sunday, and most major holidays.

- **REPAIRS** (loose bands/brackets, broken wires, broken retainers): Repair appointments are scheduled during daytime hours as they take extra time. This keeps our after-work schedule open for routine visits.

- **MISSED OR LATE-CANCELLED APPOINTMENTS**: A **$50 fee** applies to any appointment broken or cancelled with less than 48 hours' notice. Rescheduling may require a wait of 4–6 weeks, which can extend your overall treatment time. Repeat missed appointments may result in loss of scheduling privileges.
  The card on file with our office will be automatically charged.
  If an unexpected emergency occurs, please contact us — we handle each situation individually.

- **EXCESSIVE RESCHEDULING**: Frequent cancellations add to your total treatment time. If your treatment extends more than 6 months beyond your estimated end date due to rescheduling, Dr. Nayak will assess whether additional monthly fees apply.

- **GENERAL DENTIST VISITS**: Please continue seeing your regular dentist every 6 months for cleanings. Let us know your dental appointment date — we will temporarily remove your wires beforehand and replace them right after, so your treatment stays on track.

- **WAIMEA / KAMUELA OFFICE PATIENTS**: Due to limited availability at our Waimea/Kamuela location, all appointments exceeding 30 minutes — including the delivery or bonding of Clear Aligners/Invisalign and the bonding of braces — will be scheduled and completed at our Kona office. We appreciate your understanding and flexibility.

- **GRIN AT-HOME MONITORING**: If you are enrolled in our Grin at-home monitoring program as part of your treatment, weekly scans allow us to track your progress remotely through the app.
  Visits will be on demand rather than at fixed intervals. If we notice any concerns with your progress, or if you request an appointment, we will schedule you in advance. Please continue submitting your weekly scans on time to keep your treatment on track.

I have read and agree to the scheduling information above:

***Patient / Parent Signature:** ***Date:**

*(03/2025) *Mandatory field required*

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ORTHODONTIC CONSULTATION VIDEO RECORDING CONSENT FORM

Purpose of Video Recording

At Hawaiian Smiles Orthodontics, we offer the option to record your virtual consultation so you and your family can revisit treatment discussions, digital models, X-rays, treatment plans, and Q&A at any time. Recordings may be shared with the patient, parent(s)/legal guardian(s), and other authorized family members — with your consent.

Security and Privacy

Recordings will be:

- Used solely for patient education, medical documentation, and care coordination with your authorized family members and healthcare providers.
- NOT used for social media, marketing, or public display.
- Stored securely and encrypted.
- Shared only with individuals you have authorized.
- Deleted upon written request, or after 1 month — whichever comes first. After this period, the recording will no longer be retained in our system.

Consent to Record

☐ I **authorize** Hawaiian Smiles Orthodontics to record my video consultation, including all discussions, visuals, and treatment recommendations, for my personal reference.

☐ I do **not authorize** the recording of my video consultation.

Acknowledgment

By signing below, I confirm that:

- I understand the purpose of the recording and how it will be protected.
- I voluntarily consent to (or decline) the recording as indicated above.
- I understand I may withdraw or change my consent at any time without affecting my care.
- I understand that oral confirmation will also be obtained before any recording begins.

***Patient Name:** _____

Printed Name of Parent / Legal Guardian (if patient is a minor): _____

***Signature of Patient / Parent / Legal Guardian:** _____ ***Date:** _____

6/2025

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SOCIAL MEDIA & PHOTOGRAPHY RELEASE FORM

What this form means: By signing (and **not** checking the opt-out box below), you give Hawaiian Smiles Orthodontics permission to use before/after photos, videos, and images from your treatment for social media, advertising, our website, and patient education. You are **not** required to consent — declining will **not** affect your care in any way.

Full Terms:

I consent to the use of my personal image and likeness — including images depicting the treatment provided to me — by Hawaiian Smiles Orthodontics for any lawful purpose it deems appropriate, including treatment records, advertising our services to the general public (including via social media and electronic media), illustration, and publication for educational or marketing purposes.

I relinquish all rights to my likeness or any image of me obtained by photographic or digital means by Hawaiian Smiles Orthodontics during the course of treatment. I understand I am not entitled to compensation for the use of my image in any advertising, promotional, or educational materials.

I understand that any image or likeness of me may be altered before use. I agree that I have no right to be consulted about or to approve such alterations before my image is used.

Hawaiian Smiles Orthodontics will make reasonable efforts to safeguard my privacy as required by applicable law, including HIPAA. However, Hawaiian Smiles Orthodontics cannot guarantee complete privacy once an image is shared publicly or by third parties.

Hawaiian Smiles Orthodontics may include information about my health condition — such as diagnosis, course of treatment, or age — in describing the treatment shown in any image of me.

I understand that Hawaiian Smiles Orthodontics has not and will not condition my treatment upon my authorization of the use of my image or likeness.

☐ **I DECLINE — I do not want myself photographed or videotaped for social media, marketing, or educational purposes.**

***Patient Name:** _____

Printed Name of Parent / Legal Guardian (if patient is a minor): _____

***Signature of Patient / Parent / Legal Guardian:** _____ ***Date:** _____

*03/2025 *Mandatory field required*

Hawaiian Smiles
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ORTHODONTIC X-RAY / RADIOGRAPH CONSENT FORM

Purpose of X-Rays in Orthodontic Care

X-rays (radiographs) are an essential part of orthodontic diagnosis and treatment planning. They allow Dr. Nayak to:

- Assess the position of teeth, roots, and supporting bone structures.
- Identify dental or skeletal problems that may affect treatment.
- Monitor progress and confirm healthy tooth movement throughout treatment.
- Detect conditions that are not visible during a routine clinical examination.

Types of X-Rays We May Take

- **Panoramic (OPG)** — A full-mouth image showing all teeth, jaws, sinuses, and surrounding bone.
- **Cephalometric** — A side-profile X-ray of the skull used for growth analysis and treatment planning.
- **Bitewing X-rays** — Images of the back teeth; typically taken at your general dentist.
- **Periapical X-rays** — Show the full length of individual teeth, from crown to root tip.
- **CBCT (3D Cone Beam CT)** — A three-dimensional scan taken only when clinically necessary for complex cases.

Radiation Safety

We use **digital X-ray technology**, which delivers significantly lower radiation exposure than traditional film X-rays. All equipment is regularly inspected and calibrated. Lead aprons and thyroid collars are available upon request.

⚠ Pregnancy Notice

If you are pregnant or think you may be pregnant, please notify our team **before any X-rays are taken.** We will take appropriate precautions or postpone radiographs as clinically appropriate.

Consent

☐ I **consent** to X-rays/radiographs being taken as clinically determined necessary by Dr. Nayak and the clinical team.

☐ I do **not consent** to X-rays/radiographs. *Note: Declining X-rays may limit our ability to provide a complete diagnosis and safe treatment plan.*

By signing below, I confirm that:

- I understand why X-rays are used and have had the opportunity to ask questions.
- X-rays will only be used for diagnosis and treatment purposes.
- I may ask about the type of X-rays to be taken at any time.
- I may withdraw this consent in writing at any time, understanding it may affect the care I receive.
- If treatment is not started at our office, a records release fee of $250 will apply for X-rays to be released to me.

***Patient Name:** **Date of Birth:**

Printed Name of Parent / Legal Guardian (if patient is a minor):

***Signature of Patient / Parent / Legal Guardian:** ***Date:**

Records & X-Ray Release Policy

Orthodontic records, including X-rays, are the property of Hawaiian Smiles Orthodontics. There is no charge for X-rays taken as part of your records when treatment is completed at our office. However, if orthodontic treatment is not initiated at our office and you request that your X-rays or records be released directly to you or transferred to another provider, a **records release fee of $250** will be collected prior to the release of any records. We reserve the right to charge this fee and will not release records until it has been paid in full.

By signing above, you acknowledge that you have read and understood this policy.

*2025 *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:

- Obtain a copy of your paper or electronic medical record.
- Request that your medical record be corrected.
- Request confidential communications.
- Ask us to limit the information we share.
- Receive a list of those with whom we have shared your information.
- Receive a copy of this privacy notice at any time.
- Choose someone to act on your behalf.
- File a complaint if you believe your privacy rights have been violated.

YOUR CHOICES

You have some choices in how we use and share your information when we:

- Tell family and friends about your condition.
- Provide disaster relief services.
- Raise funds.

We will never use or share your information for marketing purposes or sell it without your written permission.

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.
- Do research.
- Comply with the law.
- Work with a medical examiner or funeral director.
- Address workers' compensation, law enforcement, and other government requests.
- Respond to lawsuits and legal actions.

YOUR RIGHTS — IN DETAIL

Get a copy of your medical record

You can ask to see or receive a copy of your medical record and other health information we have about you. Submit your request in writing. We will respond within 30 days. A reasonable cost-based fee may apply.

Ask us to correct your medical record

You can ask us to correct information you believe is incorrect or incomplete. If we deny your request, we will inform you in writing within 60 days.

Request confidential communications

You can ask us to contact you in a specific way or to send mail to a different address. We will honor all reasonable requests.

Ask us to limit what we use or share

You can ask us not to use or share certain health information. We are not required to agree, but if we do agree, we are bound by it. If you pay for a service out-of-pocket in full, you can ask us not to share that information with your insurer.

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

You can request an accounting of disclosures made in the past six years. We provide one free accounting per year; additional requests within 12 months may incur a fee.

Get a copy of this notice

You can request a paper copy of this notice at any time, even if you agreed to receive it electronically.

Choose someone to act for you

If you have given someone medical power of attorney or they are your legal guardian, that person may exercise your rights. We will verify their authority before acting.

File a complaint

Contact our Privacy Officer (listed at the end of this notice) or file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights at 1-877-696-6775 or www.hhs.gov/ocr/privacy/. We will not retaliate against you for filing a complaint.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.

- We will notify you promptly if a breach occurs that may have compromised your health information.
- We must follow the duties and privacy practices described in this notice and provide you with a copy.
- We will not use or share your information other than as described here unless you give us written permission. You may change your mind at any time.

CHANGES TO THIS NOTICE

We can change the terms of this notice at any time. Changes will apply to all health information we have about you. The updated notice will be available in our office and upon request.

This Notice is in effect as of May 1, 2023.

Our Privacy Officer is Nicole Fernandez, Administrative Lead. Contact her at: Phone (808) 247-6039 | Fax (808) 247-3643 | Email **Admin@hawaiiansmilesortho.com**. We will **never** sell or market your personal information.

Hawaiian Smiles
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Notice of Privacy Practices — Acknowledgement

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights regarding the privacy of my protected health information. I understand this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up care among the providers involved in my care.
- Obtain payment from third-party payers such as insurance carriers.
- Conduct normal healthcare operations.

I have received, read, and understand the *Notice of Privacy Practices*. I understand that Hawaiian Smiles Orthodontics has the right to change its Notice of Privacy Practices and that I may request a current copy at any time.

I understand that I may request in writing that you limit how my private information is used or disclosed. I also understand that you are not required to agree to my requested restrictions, but if you do agree, you are bound by them.

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

Staff Name (Print): **Date:**

☐ Individual refused to sign.
☐ Communication barriers prevented obtaining the acknowledgement.
☐ An emergency situation prevented us from obtaining acknowledgement.
☐ Other (please specify):

(03/2023)