Aloha Family Dentistry Hawaii

Christopher Young, D.D.S.

Patient Information

Full Name: _____ Nickname:_____

Address: _____ City: _____ State: _____ _ Zip: _____

Birthdate: _____ SSN: _____ Marital Status: [ ] Married [ ] Single [ ] Other

Phone # Cell: _____ E-Mail: _____

Occupation: _____ Company: _____

Emergency Contact: Name: _____ Relationship: _____ Phone #: _____

How did you hear about our office? [ ] Yelp [ ] Google [ ] Facebook [ ] Friend: _____ [ ] Other

Dental Insurance Information

Primary Insurance: _____ Subscriber Name: _____ DOB: _____

Group #: _____ Subscriber ID/SSN: _____ Relation to patient: _____

Second Insurance: _____ Subscriber Name: _____ DOB: _____

Group #: _____ Subscriber ID/SSN: _____ Relation to patient: _____

With dental insurance, we strive for you to receive your maximum benefits. While we assist you with billing your insurance company, you are primarily responsible for determining what your insurance will cover, and responsible for any balance not paid by your insurance.

Office Policy

- I understand that there will be a fee of $50 applied to my account for any cancelations without 48 hours notice (This includes No Shows). ***Initials X_____***
- I understand that if I am 15+ minutes late, my appointment will have to be rescheduled. ***Initials X_____***

Financial Policy

- I understand that my patient portion is due at the time of service. ***Initials X_____***
- I understand that any services performed without previous financial arrangement must be paid in full at the time service is rendered. ***Initials X_____***

  ****We accept ALL major credit cards, personal checks, Care Credit, and cash****
- Checks that are returned to our office from your financial institution are subject to a $**25.00** returned check fee. This fee covers the processing fees that are charged to our office. ***Initials X_____***

Authorization

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- I authorize and request the insurance company to pay directly to the dentist or dental group insurance payments otherwise payable by me. ***Initials X_____***
- I understand that I am financially responsible for all charges whether or not paid by insurance. ***Initials X_____***
- I hereby authorize the doctor to release all information to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. ***Initials X_____***
- I authorize the following person(s) access to my account. Releasing information pertaining to myself such as dates or treatment attendance, financial agreements, diagnosis, etc.

_____

Name Relationship

_____

Name Relationship

Acknowledgement of receipt of Notice of Privacy Practices

You may refuse to sign the acknowledgement

- I have read and understood Aloha Family Dentistry's Notice of Privacy Practices. ***Initials X_____***
- I understand I have access and may receive a copy of the Notice of Privacy Practices at any time. ***Initials X_____***

I have read the above conditions of treatment and payment and agree to their content.

Responsible Party Signature _____ Date _____

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Dental History

Previous Dentist: _____ Office Phone #: _____

Date of last dental visit: _____ Date of last X-rays taken:_____

As your dental office what is the most important thing we can do for you?

[ ] Preventative [ ] Affordable [ ] Cosmetic [ ] Time [ ] Other: _____

Please indicate below only if it applies to you:

1. Are you fearful of dental treatment? **YES or NO**

(If YES, please rate) Low Fear 1 2 3 4 5 6 7 8 9 10 High Fear

2. Have you had an unfavorable dental experience? **YES or NO**
   (If YES, please explain):_____
3. Difficulties with local anesthetic? (getting numb) **YES or NO**
4. Orthodontic Treatment? **YES or NO** If YES, How long ago? _____
   Do you use a retainer? **YES or NO**
5. Any adult teeth previously removed? **YES or NO**
6. Previously been treated for gum disease? **YES or NO**
7. How often do you; brush _____ X a day floss_____ X a day
8. Do your gums bleed? **YES or NO**
9. Do you use an electric toothbrush? **YES or NO**
10. Do you use a waterpik? **YES or NO**
11. Jaw complications? **YES or NO**
    (If YES please circle): Popping Clicking Locking Pain Difficulty opening
12. Any cavities within the past 3 years? **YES or NO**
13. Any sensitive teeth? **YES or NO**
    (If YES please circle)Hot Cold Sweets Biting Other:_____
14. Catch yourself clenching or grinding your teeth? **YES or NO**
15. Currently use a night guard appliance? **YES or NO**
16. Experienced burning sensation in mouth? **YES or NO**
17. Difficulty biting into hard foods? **YES or NO**
18. Teeth feel loose without injury? **YES or NO**
19. Food gets caught between teeth frequently? **YES or NO**
20. Have difficulties chewing? **YES or NO**
21. Notice gum recession or notches on your teeth near the gum line? **YES or NO**