Welcome to Honu Smiles Pediatric Dentistry!

Patient Information

Patient Name:_____ Nickname/Preferred Name:_____ Today's Date:_____
Last First MI

Birth Date:_____ Age:_____ Social Security #:_____ ☐ Boy ☐ Girl

Names and ages of brothers and sisters _____

Responsible Party Information

Name:_____ ☐ Married ☐ Single ☐ Other

Social Security #:_____ Birth Date: _____

Phone (Home):_____ (Work):_____ (Cell):_____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employer Information:_____
Name Street City State Zip Code

E-mail address:_____

Name:_____ ☐ Married ☐ Single ☐ Other

Social Security #:_____ Birth Date: _____

Phone (Home):_____ (Work):_____ (Cell):_____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employer Information:_____
Name Street City State Zip Code

E-mail address:_____

Insurance Information

Primary

Insurance Plan Name and Address: _____

_____

Name of subscriber: _____
Last First MI

Subscriber's Birth Date:_____ ID #:_____ Group #:_____

Subscriber's Address: _____
Street City State Zip Code

Subscriber's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Secondary

Insurance Plan Name and Address: _____

_____

Name of subscriber: _____
Last First MI

Subscriber's Birth Date:_____ ID #:_____ Group #:_____

Subscriber's Address: _____
Street City State Zip Code

Subscriber's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other_____

Name of person or office who referred you to our practice: _____

Health Information

Patient Name:_____ Name child goes by:_____
Birth Date:_____Age:_____ Gender: M F

1. Has there been any change in your child's general health in the last year?..... ☐Yes ☐No
2. Has your child been hospitalized in the last two years? ..... ☐Yes ☐No
3. Does your child have a heart condition or heart murmur? ..... ☐Yes ☐No
4. Have you been told that your child should have antibiotics before dental visits? ..... ☐Yes ☐No
5. Does either your family or your child have a history of complication from general anesthesia? ☐Yes ☐No
6. Has your child ever had radiation therapy? ..... ☐Yes ☐No

7. Are your child's immunizations up to date? ..... ☐Yes ☐No
8. If applicable, is the patient taking birth control medication? ☐Yes ☐No
9. Is the patient pregnant? ..... ☐Yes ☐No

*If you answered yes to any of the questions above; please explain in detail:

_____

_____

_____

10. Date of last physical exam:_____Name of Physician:_____Phone:_____
11. List all of your child's **allergies**, include adverse reactions to any drugs, medication, latex, foods:

_____

_____

Has your child ever been diagnosed with any of the following? Please check those that apply:

☐ ADD/ADHD	☐ Diabetes	☐ Intellectually Disabled	☐ Sickle Cell anemia
☐ AIDS or HIV positive	☐ Developmental Delay	☐ Jaundice/Liver disease	☐ Skin conditions
☐ Anemia	☐ Ear disorders	☐ Jaw joint pain	☐ Speech Delay/Therapy
☐ Arthritis	☐ Eating disorders	☐ Kidney Disease	☐ Stomach Problems
☐ Asthma	☐ Endocrine disorders	☐ Lung Disease	☐ Thyroid problems
☐ Autism	☐ Epilepsy/Seizures	☐ Organ Transplant	☐ Tonsils/Adenoids surgery
☐ Behavioral problems	☐ Eye disorders	☐ Pacemaker	☐ Tuberculosis
☐ Blood disease	☐ Excessive Bleeding	☐ Premature birth	☐ Tumors
☐ Bone/joint problems	☐ Head Injuries	☐ Psychiatric treatment	☐ Upper respiratory infection
☐ Cancer/Tumor	☐ Hemophilia	☐ Radiation Treatment	☐ Other_____
☐ Cerebral Palsy	☐ Hepatitis (any type)	☐ Respiratory Problems	
☐ Chemical Dependency	☐ High blood pressure	☐ Rheumatic Fever	
☐ Cleft lip/palate	☐ Injuries to Face/Mouth	☐ Seizures	

Please explain the condition further and/or list any other condition your child might have:_____

_____

List any **medications** your child is currently taking: _____

Dental History information

Is this your child's first visit to the dentist?..... ☐ Yes ☐ No Previous Dentist:_____

Date of last visit:_____Reason for visit?_____Date of last x-rays:_____

To the best of my knowledge, the preceding answers and information provided are true and correct. If there is ever any change in my child's health, I will inform the doctors at the next appointment without fail.

_____ Date:_____
Signature of Parent or Legal Guardian

_____ Date:_____
Doctor's Signature

Consent for Treatment

As a minor child, it is necessary that signed permission be obtained from the parent or legal guardian before any dental treatment can begin. **It is also necessary for minor patients to be accompanied by an adult of legal age and who can give legal consent for treatment at each appointment.**

It is our intent that all care shall be of the best possible quality for each child. Providing high quality care can sometimes be made very difficult, or even impossible, because of the lack of cooperation of some child patients. Among the behaviors that can interfere with the proper provision of quality dental care are: hyperactivity, resistive movements, refusing to open mouth or keep it open long enough to perform the necessary dental treatment, and even aggressive or physical resistance to treatment, such as kicking, screaming and grabbing the dentist's hands or dental instruments.

We make every effort to maintain the cooperation of young patients using warmth, humor, friendliness, persuasion, gentleness, love, and positive reinforcement. We find one-on-one communication to be most effective in gaining rapport and trust with your child. There are occasions where additional behavior management may be required to gain cooperation and prevent children from injuring themselves or dental staff. The following is a list of the behavior management techniques that are recommended by the American Academy of Pediatric Dentistry:

Tell-show-do: The dentist or assistant explains to the child what is to be done using simple terminology and repetition and then shows the child what is to be done by demonstrating with instruments. The procedure is then performed in the child's mouth as described. Praise is used to reinforce cooperative behavior.

Positive reinforcement: This technique rewards the child who displays any behavior that is desirable. Examples of rewards include compliments, encouragement, praises, or prizes.

Voice Control: The attention of a disruptive child is gained through lowering or raising the tone and volume of the dentist's voice. Care is taken not to make the child feel threatened. Content of the conversation is less important than the manner in which it is communicated.

Mouth Props a.k.a. "tooth pillow": A soft, rubber device used to assist the child in keeping their mouth open during a procedure and prevent their jaw from getting tired. This can also prevent accidental injury to the dentist's fingers.

Protective Stabilization - Only used if absolutely necessary. The dentist/assistant gently protects the child from movement by holding the child's hands, stabilizing the child's head or positioning the child safely in the dental chair, and/or utilizing stabilization

Nitrous Oxide Gas - These are specific techniques that will be used in this office with further discussion, explanation, separate verbal and written consent from a parent/guardian, and another dental appointment.

I hereby state that I have read and understand this consent, and that all questions about the procedure or procedures have been answered in a satisfactory manner. I understand that I have the right to be provided with answers to questions that may arise during the course of my child's treatment. I acknowledge that the above information is correct and grant this office permission to provide my child's dental and related medical/surgical treatment as deemed necessary, utilizing proper and acceptable methods used in the specialty of pediatric dentistry to complete same treatment, including diagnostic radiographs. I give my consent for the administration of local anesthetics and nitrous oxide (laughing gas). If my child ever has a change in his/her health or his medications change, I will inform the doctor at the next appointment without fail. At no time will care be rendered to a child without informing the parent or guardian of such care. For specific procedures, further information will always be provided. I further understand that this consent will remain in effect until such time that I choose to terminate it by written request.

_____ _____

Signature of Parent or Legal Guardian Date

Honu Smiles Pediatric Dentistry Office Policies

No-Show/Broken appointments:
We request that you give us at least a **24 hour notification** if you are unable to keep an appointment. Not only is this a general courtesy, but this allows us to schedule other patients who may be waiting to be seen. If you miss an appointment without contacting our office within the required time, this is considered a broken appointment. A fee of **$60.00 per scheduled patient** will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled without payment of this fee. If you have any questions regarding this policy, please let our staff know and we will be happy to address your concerns. We understand that circumstances may occur which may keep you from attending an appointment, however, **after the third failed appointment without proper notification, we will assist you in making arrangements to have your child's care** transferred to another dentist.

Late arrivals:
We value your time, therefore we make every effort to stay on schedule. Arriving late to your child's appointment does not allow time for the treatment planned for that appointment. If you arrive later than 10 minutes we may ask you to reschedule on a different date. Sometimes it is better to reschedule than to keep your family waiting. Calling to tell us that you will be late beyond 10 minutes will be considered a failed appointment.

Financial Responsibility:
Full Payment is expected at the time of service. Major credit cards, checks and cash are accepted. For patients with dental insurance, the co-insurance, deductible and non-covered expenses are due at the time of service. If you provide us with your insurance information and card, as a courtesy to our patients, we will complete insurance claim forms at our expense. The office will file to your insurance company the portion which should be covered by them. Billing by our office requires staff time and materials which result in higher fees. **To avoid any misunderstandings we ask that you take care of the financial portion at each appointment.**

Your signature below signifies that you have read and understand the policies explained in these paragraphs. By signing this form, you accept financial responsibility for this patient, authorize the release of any information necessary to process insurance claims and authorize insurance payments to Honu Smiles Pediatric Dentistry. You agree to inform the appropriate staff of Honu Smiles Pediatric Dentistry of any changes in the financial arrangements prior to treatment.

_____ _____

Child's Name Date of Birth

_____ _____ _____

Signature of Guarantor of Payment/Responsible Party Date Relationship to Patient

Honu Smile Pediatric Dentistry
Cell Phone &Cameras and Video-taping Policy

Thank you for choosing our office for your child's dental needs. To respect the privacy of other families in the treatment area, we restrict any use of phones, cameras and video-taping in any form.

To maintain the practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to the following office policy regarding use of cell phones, cameras, and video-taping.

_____ Date: _____

Print Name

_____

Signature

Confidentiality Policy

I have read and agree with the notice of Privacy Practices for Honu Smiles Pediatric Dentistry (HIPPA form).

I understand that my healthcare information is protected. I understand that, in order for a member of the Honu Smiles Pediatric Dental Team to leave detailed messages containing specific dental information on my voicemail or answering machine, I need to give permission for them to do so.

Consent for Shared Information with Family & Friends

Under the HIPPA Privacy Law Honu Smiles Pediatric Dentistry is permitted and we may make a professional judgment that certain disclosures are in your best interests even without this signature. I (the undersigned) understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information Form.

The name(s) listed below are family members or friends to whom I grant permission for Dr. John William Chang and his representatives at our clinic to verbally discuss my care using their best judgment and grant them permission to disclose dental information that is relevant to my child's care or relevant payment.

	Name	Relationship	Phone Number
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time. This consent will be considered valid until such time that I revoke it in writing. I reserve the right to revoke it at anytime.

_____ _____ _____

Signature of Parent or Legal Guardian | Date | Relationship to Patient

HONU SMILES PEDIATRIC DENTISTRY

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH 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.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail(e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, You may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer:	**Laura Chang**
Telephone:	**808-738-2115**
Fax:	**808-495-0582**
Email:	**honusmiles@gmail.com**
Address:	**95-1105 Ainamakua Drive Suite 202 Mililani, HI 96789**