



**Marcus A. Hannah, DDS**

970 N. Kalaheo Avenue, Suite A305 Kailua, HI 96734  
tel: 808.254.5454 fax: 808.254.5427  
www.drmarcushannah.com

Thank you for selecting our dental team! The information you provide in these forms is kept confidential and will help us provide the best dental care we know how.

Today's Date: \_\_\_\_\_

**Patient Information**

Patient name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Gender:  Male  Female Family Status:  Single  Married  Child Date of Birth: \_\_\_\_\_

Phone #'s (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ Ext: \_\_\_\_\_

Email: \_\_\_\_\_ (Cell #/ pgr) \_\_\_\_\_ Best time to call: \_\_\_\_\_

Where do you prefer to receive calls?  Home  Work  Cell  Pager

Home Address: \_\_\_\_\_  
Street Apartment / Unit # City State Zip

Mailing Address (if different) \_\_\_\_\_  
Street City State Zip

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Address: \_\_\_\_\_  
Street Suite # City State Zip

Spouse's Information: Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

Employer: \_\_\_\_\_ Work or Cell#: \_\_\_\_\_

Military Family Members: Estimated PCS date: \_\_\_\_\_

In case of an emergency, who should we contact? \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency contact phone numbers: \_\_\_\_\_

Whom may we thank for referring you to our practice? \_\_\_\_\_

**Insurance Information**

**#1 Primary Dental Coverage:**

Ins. Company: \_\_\_\_\_ Group #: \_\_\_\_\_

Ins. Company Address \_\_\_\_\_ Ins. Co. Phone #: \_\_\_\_\_

Patient's relationship to insured / employee:  Self  Spouse  Child  Other \_\_\_\_\_

Name of the Insured employee /Policy holder: \_\_\_\_\_ Is insured a patient?  Y  N

Insured's Birth Date: \_\_\_\_\_ Social Security Number or Subscriber ID# \_\_\_\_\_

**#2 Secondary Dental Coverage:**

Ins. Company: \_\_\_\_\_ Group #: \_\_\_\_\_

Ins. Company Address \_\_\_\_\_ Ins. Co. Phone #: \_\_\_\_\_

Patient's relationship to insured / employee:  Self  Spouse  Child  Other \_\_\_\_\_

Name of the Insured employee /Policy holder: \_\_\_\_\_ Is insured a patient?  Y  N

Insured's Birth Date: \_\_\_\_\_ Social Security Number or Subscriber ID# \_\_\_\_\_

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Our office is not like most other dental offices. This may be the most important dental visit you will ever have. We place a high emphasis on helping you determine your present and future dental needs. Here are some things we are going to be talking about at your first visit. These are issues you have probably never thought of. Please check what best expresses how you feel about the following questions:

- Are you having any areas of concern? \_\_\_\_\_
- Tell us, in your opinion, what you think the present state of the health of your mouth is?  
\_\_\_\_\_
- How healthy do you want us to get your mouth?
  - The best it can be
  - Average
  - Don't really care
- Should you need treatment, at what point should we address it?
  - When something is not ideal
  - When something is worsening
  - When something hurts or breaks
- What quality of dentistry do you want us to recommend?
  - Ideal / The Best
  - Average
  - Just patch it
- We have the ability to look at your mouth from 3 different perspectives. What combination of these would you like us to use for you?
  - As a **Functional** Dentist
  - As a **Cosmetic** Dentist
  - As a **General** Dentist
- How do you feel about the appearance of your face and smile? \_\_\_\_\_  
\_\_\_\_\_
- What would it take for you to trust us to be your dentist? \_\_\_\_\_  
\_\_\_\_\_
- Tell us about your **good** dental experience... \_\_\_\_\_  
And the **bad** ones... \_\_\_\_\_
- Has fear ever been an issue for you in a dental office? \_\_\_\_\_
- What caused you to leave your last dental office? \_\_\_\_\_
- Has time ever been a factor in getting your dental work done? \_\_\_\_\_
- Has the cost of dental treatment been a concern for you? \_\_\_\_\_  
What can we do to help you with this? \_\_\_\_\_

Is there any additional information you would like us to know? \_\_\_\_\_  
\_\_\_\_\_

### Health Information

We understand that you are here for us to help you care for your teeth and gums. Medications you are taking and health problems you may have could make a difference in how we treat your dental problems. Thank you for your assistance.

Physician Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Do you see a Specialist? (For example: Cardiologist, Orthopedist, Internist, etc)

Medical Specialist Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Are you currently under the care of a physician?  Yes  No If yes, for what? \_\_\_\_\_

When did you last visit your physician? \_\_\_\_\_

You consider your health to be:  Excellent  Good  Fair  Poor

Have you been admitted to a hospital, had surgery or needed emergency care during the past two years?  Yes  No

If yes, please explain: \_\_\_\_\_

#### Medications

Please list what medications you are taking, including "over the counter", (i.e. aspirin, vitamins, etc.)

_____	_____	_____
_____	_____	_____
_____	_____	_____

Please answer the following by circling yes (Y) or no (N):

**Are you allergic to any of the following?**

Y/N	Aspirin	Y/N	Erythromycin	Y/N	Penicillin
Y/N	Codeine	Y/N	Metal/Jewelry	Y/N	Tetracycline
Y/N	Dental Anesthetics	Y/N	Latex	Other:	_____

**Do you have or ever had any of the following conditions:**

#### Heart Problems

Y/N	Heart Murmur	Y/N	Pacemaker		
Y/N	heart defect	Y/N	Angina	Y/N	High Blood Pressure
Y/N	Bruise easily	Y/N	Stroke	Y/N	Anemia
Y/N	Mitral Valve Prolapse	Y/N	Artificial Heart Valve	Y/N	Heart (Attack, Surgery)

Did you know: Gum disease and dental infections may increase the risk of stroke and coronary heart disease?

#### Bleeding

Y/N	Excessive bleeding	Y/N	Blood Transfusion	Y/N	Take blood thinning medication
Y/N	Hepatitis _A _B _C	Y/N	Jaundice		

#### Diabetes

Y/N	Type 1 Diabetes	Y/N	Type 2 Diabetes	Y/N	Diet (Special/Restricted)
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\* Did you know: Recent studies have shown a link between diabetes and periodontal (gum) disease?

It is important to your health that they both are under control. The warning signs of diabetes are frequent trips to the bathroom, thirsty all the time, and always feeling hungry.

#### Breathing/Lungs

Y/N	Sinus problems	Y/N	Asthma	Y/N	Snoring *Ask your spouse!*
Y/N	Seasonal Allergies	Y/N	Emphysema	Y/N	Hard to breathe through nose
Y/N	Tuberculosis	Y/N	Bronchitis	Y/N	Wake up tired

#### Cancer

Y/N	Radiation Therapy	Y/N	Chemotherapy	Cancer Type:	_____
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#### Immune System

Y/N	Lupus	Y/N	Organ Transplant	Y/N	HIV / AIDS
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#### Nerves/Muscles/Bones

Y/N	<input type="checkbox"/> Head Injury	Y/N	Arthritis	Y/N	Thyroid Condition
Y/N	<input type="checkbox"/> Vertigo	Y/N	Back problems	Y/N	Epilepsy
Y/N	Tinnitus (ringing in ears)	Y/N	Scoliosis	Y/N	<input type="checkbox"/> Migraines / <input type="checkbox"/> Headaches
Y/N	Bell's Palsy	Y/N	Ear Congestion	Y/N	Paresthesia of fingertips (tingling)
Y/N	Trigeminal Neuralgia				

Y/N  Artificial Joints: Placed When? \_\_\_\_\_ Which joint? \_\_\_\_\_

**General Questions**

Y/N Do you use tobacco? Type: Cigarettes Cigar Chew How much? \_\_\_\_\_

Y/N Have you been told you have Acid Reflux? \_\_\_\_\_

Y/N Do you use Cortisone Medication? Reason: \_\_\_\_\_

Y/N Do you get Cold Sores/Fever Blisters? How often? \_\_\_\_\_

Do you have any other health problems you feel we need to know about? \_\_\_\_\_

**Women Only:**

Y/N Are you pregnant? Due Date: \_\_\_\_\_

Y/N Are you breastfeeding? \_\_\_\_\_

Y/N Are you taking birth control pills? \_\_\_\_\_

Y/N Are you on hormone therapy? \_\_\_\_\_

\* Did you know: Antibiotics can interfere with birth control pills by causing them not to work?

Also: Periodontal infections can increase the risk of low birth weights in newborns.

**Dental Information**

Reason for today's visit: \_\_\_\_\_

Name of Previous Dentist: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date of last dental visit: \_\_\_\_\_ When was your last dental cleaning? \_\_\_\_\_

Last x-rays? \_\_\_\_\_

Y/N Have you ever had a serious/difficult problem associated with any previous dental treatment?

If yes, what: \_\_\_\_\_

Y/N Are any of your teeth sensitive? If yes, to what: Cold Heat Chewing Other \_\_\_\_\_

Y/N Have you been advised to take antibiotics routinely prior to dental treatment?

Y/N Do you brush your teeth daily? How many times? \_\_\_\_\_

If you use a manual brush, what type of bristles: Hard Medium Soft

If electric brush, what brand? \_\_\_\_\_

Y/N Do you floss? How often? \_\_\_\_\_

Y/N Do your gums bleed? \_\_\_\_\_

Y/N Have you ever had gum treatment? \_\_\_\_\_

Y/N Have you had braces / orthodontic treatment? \_\_\_\_\_

Y/N Do you have any loose teeth? \_\_\_\_\_

Y/N Do you know or ever been told you grind your teeth? \_\_\_\_\_

Y/N Do you experience jaw joint: clicking popping locking jaw/muscle fatigue?

Y/N Do you have difficulty: swallowing chewing?

Y/N Do you have frequent: headaches neck or back pain?

Y/N I gag easily \_\_\_\_\_

Y/N Would you like whiter teeth? Y/N Have you whitened your teeth before? Which system? \_\_\_\_\_

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
if patient is minor = Print Name of Parent or Guardian

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relation to Patient

# *Marcus Hannah, DDS*

970 N. Kalaheo Avenue, Suite A305

Kailua, HI 96734

808.254.5454

**\* The information in this document is important, please read and initial the following.**

## **Consent for Services**

**Initial**\_\_\_\_\_ I authorize Dr. Hannah and/or staff to take x-rays, models, photographs, and other diagnostic aids deemed appropriate by Dr. Hannah to make a thorough diagnosis. Upon such diagnosis, I authorize Dr. Hannah to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

**Initial**\_\_\_\_\_ I understand that the photographs, slides, and/or x-rays will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication), and professional publications (dental magazines and journals). I further understand that if the photographs, slides, and/or x-rays are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

## **Appointment Guidelines**

**Initial**\_\_\_\_\_ Our office reserves enough appointment time to accomplish the treatment scheduled. In fairness to all our patients, and to keep our schedule on time, we request that you arrive no later than the time reserved for you; otherwise we may need to reschedule.  
On the same hand, we promise to strive to see each patient at their appointed time. We pledge a sincere effort in being prompt, but please understand unforeseen delays occur in the practice of dentistry. We will do our utmost to service you in a timely manner.  
Our office reserves the right to charge a fee for missed appointments and appointments cancelled with less than 24 hours notice.  
Failure to show for an appointment without any notice may result in dismissal from the practice for yourself and immediate family.

In order to provide the highest level of care possible we want to stress the importance of keeping the treatment areas functioning efficiently and safely. To accomplish this we kindly request that only patients come into the treatment rooms during appointments and that family members remain patiently in our reception area, unless assistance is requested. This allows us to fully concentrate on the patient's dental care and needs without distractions.

## **Dental Insurance**

Insurance coverage is a contract between you, your employer, and your insurance company. As we are not representatives of your insurance company, any insurance estimates discussed are estimates only and are not a guarantee of payment. This office will help prepare your insurance forms or assist in making collections from insurance companies and will credit any such collections to your account.

**Initial**\_\_\_\_\_ I agree to inform the office if there are ever any changes to my insurance coverage.

**Initial**\_\_\_\_\_ I understand that all dental services furnished by this office are charged directly to me and that I am personally responsible for payment of all dental services. I also understand I am responsible for paying all charges not covered by my insurance company, including all fees above what the insurance calls "usual and customary".

Our fees are reasonable and customary for quality dental care in this area but if you have dental insurance, be aware that different insurance companies use different fee schedules – which can vary greatly – we may or may not fall within what they consider usual and customary.

## **Insurance Assignment:**

I hereby authorize payment of any insurance benefits otherwise payable to me, directly to Marcus Hannah, DDS.

**Signature:** \_\_\_\_\_

**(PLEASE COMPLETE BACKSIDE)**

## Financial Policies

**Initial**\_\_\_\_\_ I understand that all dental services furnished by this office are charged directly to me and that I am personally responsible for payment of all dental services. If financial arrangements are required, they must be made in advance. I also understand that checks that are returned unpaid are subject to a fee.

- All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for before services are performed.
- A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding ninety (90) days, unless previously written financial arrangements are made.
- Any fee estimate provided by this office for dental care can only be extended for a period of ninety (90) days from the date of the patient examination.

In consideration for the professional services rendered to me by Marcus Hannah, DDS., I agree to pay the reasonable value of said services to the practice at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit were instituted hereunder.

**Initial**\_\_\_\_\_ Hawaii charges a 4.712% tax for medical and dental services. By law, we are required to collect this for the state.

\_\_\_\_\_

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

\_\_\_\_\_  
Signature of Patient (if patient is a minor, the parent, or guardian)

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Signature of guarantor of payment / party accepting financial responsibility for account

\_\_\_\_\_  
Relationship to patient

Printed Name of patient(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date



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### FINANCIAL POLICIES

In our continued commitment to provide the highest quality dental care available to all of our patients and to have those services comfortably affordable, we are pleased to offer you these options for payment:

- ❖ Cash or Check on day of service
- ❖ Visa or Mastercard on day of service
- ❖ Prepayment of services with cash or check for full amount receive 5% accounting reduction.
- ❖ Financing options available through Care Credit and Citi Health.  
(Please ask our administrative staff for details and credit applications. All extended financing must be made prior to treatment day)

**A \$50 fee will be collected for the reservation of appointments for dental treatment. This fee is needed at the time the appointment is made and will be applied towards your patient portion for the treatment. If you need to reschedule your appointment, kindly give 48 hours notice. If an appointment is cancelled without a 48 hour notice, the reservation fee will be forfeited and an additional \$50 would be required to make a new appointment.**

As a courtesy we will process your insurance benefits in our office. This will relieve you of a time consuming and sometimes complicated task.

We are here to assist you in anyway possible. Please voice your questions and concerns to our team. We want you to fully understand your dental health and are equipped to make the best choices possible.

I have read the information above and accept these terms. I acknowledge that I am fully responsible for the total payment of all services rendered in this office. This includes any treatment that is not a benefit of any dental insurance that I may have. I understand that my financial responsibility will be due at the time of service, regardless of whether or not my insurance benefits have been received.

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Printed Name of patient (s)

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Date

---

Signature of Patient, or if patient(s) is a minor, the parent, or guardian

---

Relationship to patient(s)

---

Signature of guarantor of payment/party accepting financial responsibility for account

---

Relationship to patient(s)

## NOTICE OF PRIVACY PRACTICES

***THIS NOTICE DESCRIBES HOW YOUR DENTAL INFORMATION MAYBE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS INFORMATION CAREFULLY.***

**Marcus Hannah, DDS**, uses health information about you for treatment, payment and health care operations. Your health information is contained in paper and electronic records that are the property of **Marcus Hannah, DDS**.

### **Use or Disclosure of Your Health Information**

For Treatment:

Your dentist may use your health information to provide you with dental treatment and services. For example, information obtained by your dentist will be included in your dental record that is related to your treatment. This information is necessary for your dentist to determine what treatment you should receive. Dentists will also record actions taken by them in the course of your treatment and note how you respond to the actions.

For Payment:

Your dentist may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a claim may be sent to your insurance carrier from your dentist, in order for your insurance carrier to make payment based upon your dental benefits coverage. The information on the claim will include information that identifies you, your diagnosis and treatment or supplies used in the course of treatment.

For Health Care Operations:

Your dentist may use and disclose health information about you for operational purposes. For example, your dental information may be disclosed to your dental insurance carrier to:

- Evaluate the performance of your dentist;
- Assess the quality of care and outcomes in your cases and similar cases; and
- Learn how to improve our services to you.

Appointments:

Your dentist may use your information to provide appointment reminders or information about treatment alternatives or other dental-related benefits and services that may be of interest to you.

Required by Law:

Your dentist may use and disclose information about you as required by law. For example, your dentist may disclose information for the following purposes:

- For judicial and administrative proceedings pursuant to legal authority;
- To report information related to victims of abuse, neglect or domestic violence; and
- To assist law enforcement officials in their law enforcement duties.

**Public Health:**

Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury or disability, or for other health oversight activities.

**Decedents:**

Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

**Organ/Tissue Donation:**

Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

**Research:**

Your dentist may use your health information for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research.

**Health and Safety:**

Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

**Government Functions:**

Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of protected health information.

**Workers Compensation:**

Your health information may be used or disclosed in order to comply with laws and regulations related to Workers Compensation.

**Your Health Information Rights**

You have the right to:

- Request a restriction on certain uses or disclosures of your protected health information, however, your dentist is not required to agree to a requested restriction.
- Obtain a paper copy of the Notice of Privacy Practices upon request.
- Inspect and obtain a copy of your dental records held by your dentist upon request. There will be a nominal charge for this service.
- Request to amend your dental records.
- Request communications of your dental information by alternative means or at alternative locations.
- Revoke your authorization to use or disclose dental information except to the extent that action has already been taken.
- Receive an accounting of disclosures made of your information by your dentist.

**Complaints**

You may submit complaints to your dentist, insurance carrier and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

**Obligations of Your Dentist**

Your dentist is required to:

- Maintain the privacy of protected health information;
- Provide you with this notice of its legal duties and privacy practices with respect to you health information;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed;
- Accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations; and
- Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

Your dentist reserves the right to change its privacy practices and to make new provisions effective for all protected health information it maintains. As notices are revised, copies will be mailed to you within sixty (60) days of making the change.

If you have any questions or complaints, or if you do not want to provide your consent to your dentist, to use your protected health information for purposes of payment and/or health care operations, please submit a letter of denial to provide consent to:

Rachelle Manahan  
Privacy Officer

Marcus Hannah, DDS  
970 N. Kalaheo Avenue, Ste A305  
Kailua, HI 96734

## Acknowledgement of Receipt of Notice of Privacy Practices

I, \_\_\_\_\_, have reviewed a copy of this dental office's  
(printed name of patient)  
Notice of Privacy Practices.

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### **For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign.
- Communication barrier prohibited obtaining the acknowledgement.
- An emergency situation prevented us from obtaining acknowledgement.
- Other (please specify).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dental Office Signature: \_\_\_\_\_ Date: \_\_\_\_\_