Kailua Dental Arts
970 N. Kalaheo Avenue, Suite A305
Kailua, HI 96734
808.254.5454
www.KailuaDentalArts.com

Today's Date:_____

Thank you for selecting our dental team! Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.
The information you provide in these forms is kept confidential and will help us provide the best dental care we know how.

Child's First & Last Name:_____ Nickname:_____

Date of Birth:_____ ❑Male ❑Female

Home Address: _____
Street Apartment # City State Zip

Billing Address (if different)_____
Street City State Zip

Phone #'s (Home)_____ Email address:_____

Mother's Info: Name:_____ Wk # _____ Cell #:_____

Father's Info: Name:_____ Wk #_____ Cell #:_____

Parent's Marital Status: ❑Single ❑Married ❑Divorced ❑Separated

Where do you prefer to receive calls? ❑Home _____ ❑Work _____ ❑Cell _____

Who is accompanying the child today? _____ Relation to child:_____

Do you have legal custody of child? ❑Yes ❑No

Who is responsible for account? _____ Relation to child:_____

Additional persons responsible for account:_____ Relation to child:_____

Drivers Lic #: _____ SSN:_____

Other family members seen by us:_____

Previous Dentist:_____ Phone #:_____

Whom may we thank for referring you?_____

** Military Family Members: Estimated Transfer date: _____

Dental Insurance Information

Primary Dental Insurance:

Name of the Insured/Employee:_____ Is insured a patient? ❑Y ❑N

Insured's Birth Date:_____ SSN or Subscriber ID#_____

Ins. Company/Plan Name_____ Group #:_____

Ins. Address_____ Ins. Co. Phone #:_____

Secondary Dental Insurance:

Name of the Insured/ Employee:_____ Is insured a patient? ❑Y ❑N

Insured's Birth Date:_____ SSN or Subscriber ID#_____

Ins. Company/Plan Name_____ Group #:_____

Ins. Address_____ Ins. Co. Phone #:_____

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

Reason for today's dental visit:_____

Date of last dental visit: _____last dental cleaning?_____ last x-rays?_____

Y/N Has your child ever had a serious/difficult problem associated with any previous dental treatment?
If yes, what:_____

Y/N Have you ever been told to take antibiotics routinely for dental treatment?

Y/N Teeth sensitivity? If yes, to what: ❑Cold ❑Heat ☐Chewing ☐Other_____

Y/N Does your child brush their 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 Does your child floss?

Y/N Is there anything about your child's smile you would like to change? What?_____

Is your child currently under the care of a physician? ❑Yes ❑No If yes, for what?_____

Physician Name_____Phone Number_____

When did your child last visit his / her physician?_____

Medications

Please list what medications your child is taking, including "over the counter", (i.e. aspirin, vitamins, etc.)

_____ _____ _____

_____ _____ _____

Is your child allergic to any of the following? Please circle yes or no:

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:	_____
Y/N	Seasonal Allergies				

Is child receiving Fluoride? Y/N What Type: ❑Prescription Fluoride ❑Fluoridated Water

Does your child have or a history of having any of the following conditions: Please circle yes or no:

Y/N	Heart Murmur	Y/N	Congenital Heart Defect	Y/N	Rheumatic Fever
Y/N	Anemia	Y/N	Hepatitis _A _B _C	Y/N	HIV / AIDS
Y/N	Blood Disease	Y/N	Cancer	Y/N	Epilepsy
Y/N	Jaundice	Y/N	Diabetes	Y/N	Nervous Disorder
Y/N	Arthritis	Y/N	ADD / ADHD	Y/N	History of Substance Abuse
Y/N	Swollen, Stiff, Painful Joints	Y/N	Head or Face Injury	Y/N	Asthma
Y/N	Frequent Headaches	Y/N	Back problems	Y/N	Sinus problems
Y/N	Snoring	Y/N	Hard to breathe through nose	Y/N	Tendency for colds
Y/N	Ear Infections	Y/N	Tuberculosis	Y/N	Bronchitis
Y/N	Tubes in Ears -What age?_____				
Y/N	Tonsils or Adenoids Removed - What age?_____				

Does / did the child have any of the following habits? Please circle yes or no:

Y/N	Lip Sucking / Biting	Y/N	Nail Biting	Y/N	Grind teeth at night
Y/N	Nursing Bottle Habits	Y/N	Thumb Sucking	Y/N	Mouth Breather

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 child's medical status.

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

_____

Signature (of Parent or Guardian if patient is minor) Date

Kailua Dental Arts

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

Consent for Services

Initial_____ I authorize the dentist and/or staff to take x-rays, models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis and upon such diagnosis, I authorize the 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 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_____ A portion of the fee for services will be collected at the time treatment is scheduled. The amount paid will be applied towards your patient portion for services provided. If you need to change your appointment, kindly give at least a 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.

Initial_____ Failure to show for an appointment without any notice may result in dismissal from the practice for yourself and immediate family.

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".

Insurance Assignment:

I hereby authorize payment of any insurance benefits otherwise payable to me, directly one of the following:
Kailua Dental Arts, Marcus Hannah, DDS, and Lisa Sonntag, DDS.

Signature:_____

Financial Policies

Initial_____ I understand that checks that are returned unpaid are subject to a $25.00 fee.

Initial_____In consideration for the professional services rendered to me by Kailua Dental Arts staff, 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 and understand the above conditions and agree to their content.

Printed Name of patient(s): Date:

_____ _____

_____ _____

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

Acknowledgement of Receipt of Notice of Privacy Practices

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

Please Print Patient Name(s): _____

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: _____

10/2002