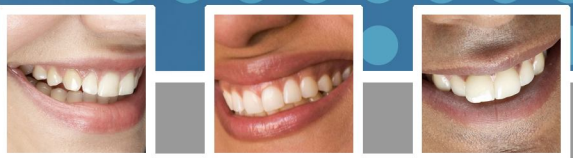
Stephen R. Ho, D.D.S.
438 Hobron Lane
Suite 209
Honolulu HI 96815
(808)949-4288



Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Prev. Visit: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Whom may we thank for referring you to our practice?

* ☐ Friend/Family Member ☐ Yelp ☐ Google
☐ Facebook ☐ Insurance Carrier ☐ Other (name below)

Name of person, office, or other source referring you to our practice:

_____

In the event of an emergency, who should we contact?

Name & Phone Number:

* _____

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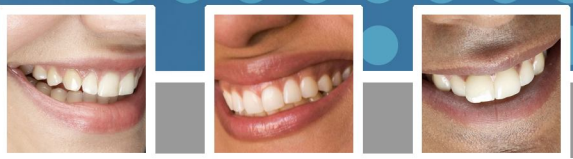

Primary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ _____ _____ _____

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____

_____ _____ _____ _____

City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ _____ _____ _____

City State Zip Code

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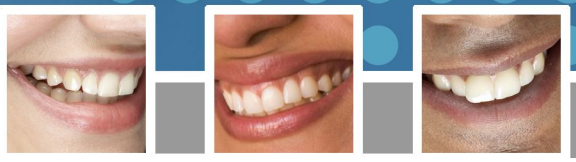

Consent Form

Authorization & Release: I authorize Stephen Ho DDS to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist, otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Privacy Policy: Prior to using or disclosing your protected health information to carry out treatment, payment or health care operations, Stephen Ho DDS is required under federal law to obtain your consent. Please review this consent, if you agree with its terms please check the box below. Should you desire a more complete description of the permissible uses and disclosures of your protected health information, you have the right to review a Notice of Privacy Practices prior to signing this consent.

Late Charges: If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this account or any future outstanding account balances.

Missed Appointment Fee: Patients who do not show up on time for an appointment, or cancel with less than 24 hours notice will be charged a $50 fee. This fee must be paid before a new appointment is scheduled.

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

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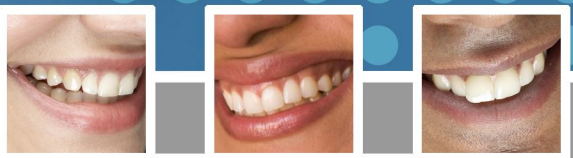

Health History

When was your last dental visit? Reason for visit?

Please check the box if you expierence any of the following:

- ☐ Do your gums bleed while brushing?
- ☐ Do your gums bleed while flossing?
- ☐ Do you feel pain to any of your teeth when brushing or flossing?
- ☐ Are your teeth sensitive to hot, cold, sweet, or sour foods/liquids?
- ☐ Have you noticed any loosening of your teeth?
- ☐ Does food tend to become caught between your teeth?
- ☐ Do you have any sores or lumps in or near your mouth?
- ☐ Have you ever experienced clicking of your jaw?
- ☐ Difficulty opening or closing your jaw?
- ☐ Difficulty chewing?
- ☐ Have you had any head, neck, or jaw injuries?
- ☐ Do you have frequent headaches?
- ☐ Do you clench or grind your teeth while awake or asleep?
- ☐ Do you bite your lips or cheeks frequently?
- ☐ Have you ever had Orthodontic treatment (braces)?
- ☐ Have you ever had Oral Surgery?
- ☐ Have you ever worn a bite guard or night guard?
- ☐ Have you ever had an upsetting dental experience?
- ☐ Have you had any abnormal bleeding?
- ☐ Do you bruise easily?
- ☐ Do you use tobacco?

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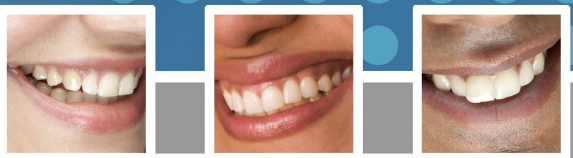

☐ Do you use alcohol or other drugs?

☐ Do you have any disease, conditon or problem we should know about?

Please explain if there is anything we should be aware of regarding your health:

Please check the box if you are allergic to any of the following:

☐ Local anesthetics like novocaine
☐ Penicillin or other antibiotics
☐ Sulfa drugs
☐ Barbiturates, seditives or sleeping pills
☐ Aspirin
☐ IodineLatex

Please check the box if you have ever had the following:

☐ Rheumatic heart disease or rheumatic fever
☐ Scarlet fever
☐ Heart trouble, heart attack, or angina
☐ Heart defect or heart murmur
☐ Pacemaker
☐ Heart surgery
☐ High blood pressure
☐ Low blood pressure
☐ Hepatitis, jaundice or liver disease
☐ Stroke
☐ Sinus trouble
☐ Lung or breathing problems
☐ Asthma
☐ Fainting spells or seizures
☐ Diabetes
☐ AIDS or HIV
☐ Thyroid problems
☐ Joint replacement or implant
☐ Cancer
☐ Epilepsy
☐ Anemia
☐ Leukemia
☐ Acid Reflux

Please list the current MEDICATIONS you are taking (if none, please respond with 'None'):

*

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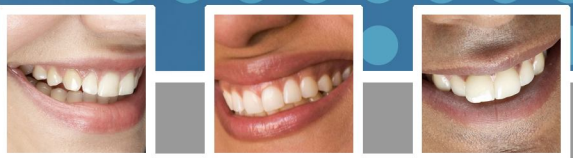

Are you under the care of a physician?

◯ Yes ◯ No

Physician Name/Medical facility:

Women Only: Please check the box if any statement applies to you:

☐ Are you pregnant or think you may be pregnant ☐ Are you nursing

☐ Are you on any birth control

Please read the following and check the box below to confirm you have read and understand the consent for services:

I understand the risks inherent in the treatment(s). I have discussed these risks with the dentist. The dentist has addressed all questions and concerns I have presented. I understand the expected results of the procedure(s) or course(s) of treatment. I understand that these results cannot be guaranteed and may not be achieved. I am aware of my right to waive treatment of any kind and I am aware of the possible consequences of non-treatment.

I have disclosed my health history information, including allergies, reactions to medicine, diseases, and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or course(s) of treatment.

I authorize Stephen Ho DDS and any other qualified assistants or medical professionals to perform the procedure(s) or treatment(s) needed for my dental health. I also give my consent for these individuals to administer any needed medicine and to perform any compulsory life-saving procedures.I confirm that I understand this form and the information contained therein.

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

Response Date: