Douglas W. Shafer, DDS, PC Hawaiian Smiles

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask—we are happy to help!

PATIENT REGISTRATION

Date:

PERSONAL INFORMATION

Name: _____ Preferred Name: _____

Address: _____

City, State, Zip Code: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____

Social Security Number: _____ Female: _____ Male: _____

Single: _____ Married: _____ Divorced: _____ Widowed: _____

Email Address: _____

How were you referred to our office? _____

DENTAL INSURANCE

PRIMARY CARRIER

Insurance Company: _____

Group #: _____ ID#: _____

Employer Name: _____ Insured Name: _____

Insured ID#: _____ Insured SSN: _____

Date of Birth: _____ Relationship to Patient: _____

SECONDARY CARRIER

Insurance Company: _____

Group #: _____ ID#: _____

Employer Name: _____ Insured Name: _____

Insured ID#: _____ Insured SSN: _____

Date of Birth: _____ Relationship to Patient: _____

ACCOUNT INFORMATION

Person Financially Responsible for Account: _____

Employer: _____ Occupation: _____

Phone Number: _____

Spouse Name: _____

Employer: _____ Occupation: _____

Phone Number: _____

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

Phone Number: _____

Name _____

OUR FINANCIAL POLICY & CONSENT FOR TREATMENT

The following is a statement of our Financial Policy and Consent for Treatment, which we require you read and sign prior to any treatment performed. Please let us know if you have any questions. Thank you!

FULL PAYMENT IS DUE AT THE TIME OF SERVICE

We realize every person's financial situation is different. For this reason we have worked hard to provide a variety of payment options to help you receive the dental care needed to enjoy a healthy and confident smile with respect to your budget. Please note however, that payment in full is expected at the time of service. Hawaiian Smiles gladly accepts cash, checks, and all major credit cards.

DENTAL INSURANCE

We are happy to file the forms necessary to see that you receive full benefits of your coverage; however, we cannot guarantee any estimated coverage. Your insurance policy is an agreement between you and the provider; therefore, we ask that all patients be directly responsible for all outstanding charges. If for some reason your insurance company has not paid their portion within 60 days from the start of treatment, you will be held responsible for payment at that time.

CONSENT FOR TREATMENT

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me, and to employ such assistance as required, to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used to disclose and that a notice fully outlining the protection of my personal health information is available.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1.75% late charge may be added to my account. If required, I also understand a check of my credit history may be made.

MINOR PATIENTS

The adult accompanying a minor and the parents (or legal guardian) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been preauthorized to an approved credit plan, credit card or payment by cash or check, at the time of service.

MISSED & CANCELLED APPOINTMENTS

Unless cancelled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $60.00 per scheduled hour. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

X_____ Date: _____

(Patient or Responsible Party Signature)

DENTAL HISTORY

Please answer the following questions in regards to your current and previous dental history. Thank you!

What is the reason for your visit today?

_____

_____

Date of last dental visit _____ Last dental cleaning _____ Last full mouth x-ray _____
What was done at your last dental visit? _____
Previous Dentist's name: _____
Address: _____ Telephone: _____
_____

How often do you have dental examinations? _____
How often do you brush your teeth? _____ How often do you floss your teeth? _____
What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes _____ No _____
If yes, please describe: _____

Are any of your teeth sensitive to

Hot or cold?	Yes ___ No ___
Sweets?	Yes ___ No ___
Biting/chewing?	Yes ___ No ___
Have you noticed bad odor/taste?	Yes ___ No ___
Do you get cold sores, blisters, or other oral lesions?	Yes ___ No ___
Do your gums bleed or hurt?	Yes ___ No ___
Have your parents experienced gum disease/tooth loss?	Yes ___ No ___
Have you noticed change in your bite?	Yes ___ No ___
Does food tend to become caught in your teeth?	Yes ___ No ___

If yes, where? _____

Do you

Clench or grind your teeth?	Yes ___ No ___
Bite your lip or cheeks?	Yes ___ No ___
Hold foreign objects with your teeth? (pencils, nails, pipe)	Yes ___ No ___
Mouth breathe while awake or asleep?	Yes ___ No ___
Have a tired jaw in the morning?	Yes ___ No ___
Snore or have any other sleeping disorders?	Yes ___ No ___
Smoke/chew tobacco or use any other tobacco product?	Yes ___ No ___

Have you ever had

Orthodontic treatment?	Yes ___ No ___
Oral surgery?	Yes ___ No ___
Periodontal treatment?	Yes ___ No ___
Your teeth ground or a bite adjustment?	Yes ___ No ___
A bite plate or mouth guard?	Yes ___ No ___
A serious injury to the mouth or head?	Yes ___ No ___

If so, please explain: _____
_____

Have you experienced

Clicking or popping of the jaw?	Yes ___ No ___
Pain? (joint, ear, side of face)	Yes ___ No ___
Difficulty opening or closing your mouth?	Yes ___ No ___
Headaches or neck aches?	Yes ___ No ___
Sore muscles (neck or shoulder)?	Yes ___ No ___

Are you satisfied with your teeth's appearance?
Please explain: _____
_____

Have you had an upsetting dental experience?
Please explain: _____
_____

Is there anything else about having dental treatment that you would like us to know?

_____
_____
_____

DWS DDS

Name _____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes____	No____	If yes, please explain _____
Have you ever been hospitalized or had a major operation?	Yes____	No____	If yes, please explain _____
Have you ever had a serious head or neck injury?	Yes____	No____	If yes, please explain _____
Are you taking any medications, pills, or drugs?	Yes____	No____	If yes, please explain _____
Do you take, or have you taken, Phen-Fen or Redux?	Yes____	No____	If yes, please explain _____
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	Yes____	No____	If yes, please explain _____
Are you on a special diet?	Yes____	No____	If yes, please explain _____
Do you use tobacco?	Yes____	No____	If yes, please explain _____
Do you use controlled substances/recreational drugs?	Yes____	No____	If yes, please explain _____
Do you use cannabis or marijuana?	Yes____	No____	If yes, please explain _____

Women: Are you…

❑ Pregnant or trying to get pregnant? ❑ Nursing? ❑ Taking oral contraceptives?

Are you allergic to any of the following?

❑ Aspirin/NSAIDs ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Local Anesthetics
❑ Latex ❑ Sulfa Drugs ❑ Metal Other _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	❑ Yes ❑ No	Fainting Spells/Dizziness	❑ Yes ❑ No	Mitral Valve Prolapse	❑ Yes ❑ No
Alzheimer's Disease	❑ Yes ❑ No	Frequent Cough	❑ Yes ❑ No	Osteoporosis	❑ Yes ❑ No
Anaphylaxis	❑ Yes ❑ No	Frequent Diarrhea	❑ Yes ❑ No	Pain in Jaw Joints	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Frequent Headaches	❑ Yes ❑ No	Parathyroid Disease	❑ Yes ❑ No
Angina	❑ Yes ❑ No	Genital Herpes	❑ Yes ❑ No	Psychiatric Care	❑ Yes ❑ No
Arthritis/Gout	❑ Yes ❑ No	Glaucoma	❑ Yes ❑ No	Radiation Treatments	❑ Yes ❑ No
Artificial Heart Valve	❑ Yes ❑ No	Hay Fever	❑ Yes ❑ No	Recent Weight Loss	❑ Yes ❑ No
Artificial Joint	❑ Yes ❑ No	Heart Attack/Failure	❑ Yes ❑ No	Renal Dialysis	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Heart Murmur	❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No
Blood Disease	❑ Yes ❑ No	Heart Pacemaker	❑ Yes ❑ No	Rheumatism	❑ Yes ❑ No
Blood Transfusion	❑ Yes ❑ No	Heart Trouble/Disease	❑ Yes ❑ No	Scarlet Fever	❑ Yes ❑ No
Breathing Problems	❑ Yes ❑ No	Hemophilia	❑ Yes ❑ No	Shingles	❑ Yes ❑ No
Bruise Easily	❑ Yes ❑ No	Hepatitis A	❑ Yes ❑ No	Sickle Cell Disease	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Hepatitis B or C	❑ Yes ❑ No	Sinus Trouble	❑ Yes ❑ No
Chemotherapy	❑ Yes ❑ No	Herpes	❑ Yes ❑ No	Spina Bifida	❑ Yes ❑ No
Chest Pains	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No	Stomach/Intestinal Disease	❑ Yes ❑ No
Cold Sores/Blisters	❑ Yes ❑ No	High Cholesterol	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Congenital Heart Disorder	❑ Yes ❑ No	Hives or Rash	❑ Yes ❑ No	Swelling of Limbs	❑ Yes ❑ No
Convulsions	❑ Yes ❑ No	Hypoglycemia	❑ Yes ❑ No	Thyroid Disease	❑ Yes ❑ No
Cortisone Medicine	❑ Yes ❑ No	Irregular Heartbeat	❑ Yes ❑ No	Tonsilitis	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Kidney Problems	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Drug Addiction	❑ Yes ❑ No	Leukemia	❑ Yes ❑ No	Tumors or Growths	❑ Yes ❑ No
Easily Winded	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No	Ulcers	❑ Yes ❑ No
Emphysema	❑ Yes ❑ No	Low Blood Pressure	❑ Yes ❑ No	Venereal Disease	❑ Yes ❑ No
Epilepsy/Seizures	❑ Yes ❑ No	Lung Disease	❑ Yes ❑ No	Yellow Jaundice	❑ Yes ❑ No
Excessive Bleeding	❑ Yes ❑ No				
Excessive Thirst	❑ Yes ❑ No				

Have you ever had any serious illness not listed? _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health, or if my medicines change, I will inform the dentist at the next appointment without fail.

Because of HIPAA, Federal regulations protecting your privacy, we wish to inform you we will release no information about you without your consent. We are allowed to release this information to your insurance company or as necessary to get paid for our services. You can have access to your records by simply asking. We will give you a copy if you desire, as long as your account has a zero balance. If you feel we have release information you have the right to file a complaint. The above statement is required by Federal HIPAA regulations.

Signature of Patient or Guardian _____ Date _____