GLENN Y. KADOHIRO, DDS

154 PAPALAUA STREET • SUITE 200 • LAHAINA • HAWAII 96761 • (808) 667-7711

GRADUATE OF UNIVERSITY OF MISSOURI, KANSAS CITY
PRACTICING IN LAHAINA, MAUI SINCE 1985

My staff and I would like to welcome you to our dental practice. We are honored and appreciate that you have chosen our office for your dental care. My staff and I are trained primarily to treat the area in and around your mouth, which is the gateway to your body. The diseases of the mouth can affect your entire body and may influence your physical and emotional well being.

Our mission is to prevent disease and restore health by centering our attention to the care of your teeth, gums, bones, muscles and jaw joints.

Please answer all questions on this form concerning patient information, health history and office policies. If you have any questions, please feel free to ask us. We look forward to providing you with personal quality dental care.

Today's Date ______________________

Patient's Name (Print) ____
Last First Middle

Name you prefer we call you? ____

Social Security # ______________ Birthdate ______________ Sex: F ______ M ______

Mailing Address ____

Street Address ____

Home Phone # ______________ Cell # ______________ E-mail ______________

Employer's Name ______________________________ How Long? ______________

Work Phone #/Dept. ______________________________ Occupation ______________

If employed less than 1 year, list previous employer ______________________________

Spouse's Name (Print) ____
Last First Middle

Social Security # ______________________ Birthdate ______________________

Employer's Name ______________________________ How Long ?______________

Work Phone #/Dept. ______________________________ Occupation ______________

Person to contact in case of emergency ______________________________ Phone ______________

Relationship ______________________

How did you hear about our office? ____

HEALTH HISTORY

Any information you give us concerning your health could have an important consequence regarding your diagnosis and treatment. Please answer all of the following questions.

Why are you now seeking dental treatment? ______________________________

____

Your Physician's Name: ______________________________ Phone # ____________

Are you under the care of a physician for any illness or health problems? Yes ______ No ______

If yes: ______________________________

Has your blood pressure been checked within the last year? Yes ________ No ________

What is your estimation of your general health? Excellent ______ Good ______ Poor ______

When did you last have a complete physical examination? ______________________________

Height ________________ Weight ________________ Blood Pressure ________________

List all past hospitalizations: ______________________________

____

List any past and present cancer treatment medications and treatment for osteoporosis or osteopenia: ____________

____

List all other medications or drugs you are currently taking: ______________________________

____

Do you think your teeth are affecting your general health in any way? Yes ______ No ______

Are you dissatisfied with the appearance of your teeth? Yes ______ No ______

Are you anxious or afraid of receiving dental treatment? Yes ______ No ______

Have you ever had sores in the mouth or on lips that were slow to heal? Yes ______ No ______

Have you ever had injury to your face or jaw? Yes ______ No ______

Would you like to keep your natural teeth for a lifetime? Yes ______ No ______

When did you last receive dental treatment? ______________________________

Have you ever had an unfavorable dental experience in the past? ______________________________

Please describe what you think we can do to make your visits more comfortable? ______________________________

____

What kind of toothbrush are you using? Hard ______ Medium ______ Soft ______

How often do you brush? ____________________ How often do you floss? ____________________

HAVE YOU EVER EXPERIENCED AN UNUSUAL REACTION TO ANY OF THE FOLLOWING MEDICATIONS?

Penicillin	Yes _____	No _____	Local Anesthetic (Novocaine)	Yes _____	No _____
Tetracycline	Yes _____	No _____	Barbiturates (Sleeping Pills)	Yes _____	No _____
Antibiotics	Yes _____	No _____	Codeine	Yes _____	No _____
Aspirin	Yes _____	No _____	Latex	Yes _____	No _____

Any Other Medications or Allergies? ______________________________

____

____

APPOINTMENTS: ______ INITIAL HERE

Once you make an appointment, please remember we reserve that time especially for you. If you find it necessary to reschedule your appointment, you need to call our office **two business days in advance**. This will allow us to have another patient come in to complete their dental treatment. We will give you a confirmation call two business days before your appointment. **If you do not confirm your appointment by 12:00 p.m. the day before your appointment, you may be charged a Broken Appointment Fee of $52.08. Also, if you confirm your appointment and do not come, you may be charged a Broken Appointment Fee.** You will need to call us back to reschedule another appointment. We realize everyone's time is valuable and we appreciate our patients giving us the same consideration.

INSURANCE INFORMATION: ______ INITIAL HERE

To avoid any misunderstanding regarding dental insurance, we would like to inform our patients that all professional services are charged directly to the patient and the patient is personally responsible for payment of fees. If the patient is a minor, the guarantor will be responsible for payment of fees. We do not render our services on the basis that the insurance companies will pay our fees. Our treatment and fees are based on each individual's dental needs.

Dr. Kadohiro is a Participating Provider with HDS, HMSA and HMAA (may be subject to change). If you have dental insurance, please provide our office with your current information. At the time of service, we must be able to verify your coverage and the patient or guarantor is responsible to pay their portion and tax. All charges not reimbursed by the patient's insurance, are the patient's or guarantor's responsibility. Please inform us of any insurance changes immediately so we can avoid delays in claims processing and reimbursements.

PAYMENT PLANS: (Check One)

______ Insurance

______ Cash

______ Check

______ Credit Card (VISA, MasterCard, American Express, Discover)

______ Care Credit (Ask Financial Coordinator for details)

Patients are required to pay at the time of service. However, with approval of our Financial Manager, a payment plan may be available.

BILLING STATEMENT:

You will receive your statement in the mail soon after the billing date. Payment should be made as soon as you receive your statement. Your account is considered 30 days past due if not paid prior to the next billing date. All accounts, 30 days and over, will accumulate a finance charge of 1% per month, 12% annually. Please contact our office immediately if you have any questions regarding your statement.

COLLECTIONS:

It is agreed that in the event collections or legal action becomes necessary to collect an unpaid balance, the patient or guarantor will be responsible to pay all collection costs and attorney's fees, including appeals.

I have read all information and agree to the policies as stated above. Also, I certify that the information I have given to be true and to the best of my knowledge. If there are any changes, I will notify the office of Glenn Y. Kadohiro, DDS. I agree to the terms and conditions set forth in this document.

______________________________ ______________

PATIENT'S SIGNATURE DATE

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? INDICATE WITH A ✓

	YES	NO
TEETH SENSITIVE TO COLD, HEAT, SWEETS, PRESSURE	❑	❑
BLEEDING GUMS	❑	❑
FOOD IMPACTION	❑	❑
CLENCHING OR GRINDING	❑	❑
SWELLING OR LUMPS IN MOUTH	❑	❑
DRYNESS IN MOUTH	❑	❑
PAIN AROUND EARS	❑	❑
UNUSUAL SOUNDS IN EAR	❑	❑
BAD BREATH	❑	❑
COMPLICATIONS FROM EXTRACTIONS	❑	❑
ORTHODONTIC TREATMENT	❑	❑
MOUTH BREATHING	❑	❑
EXCESSIVE BLEEDING FROM CUTS OR EXTRACTIONS	❑	❑
AIDS/ARC/HIV +	❑	❑
ALCOHOLISM	❑	❑
ANEMIA OR BLOOD PROBLEMS	❑	❑
ANY RELATIVES WITH A DISEASE WHICH CAN BE INHERITED	❑	❑
HEARING PROBLEM	❑	❑

	YES	NO
ARTHRITIS	❑	❑
ARTIFICIAL HEART VALVE	❑	❑
ARTIFICIAL JOINT	❑	❑
ASTHMA	❑	❑
BRUISE OR BLEED EASILY	❑	❑
CANCER	❑	❑
CHEST PAIN	❑	❑
CHEW TOBACCO	❑	❑
CONGENITAL HEART DISEASE	❑	❑
DIABETES	❑	❑
DO YOU SMOKE	❑	❑
EPILEPSY	❑	❑
FAINTING	❑	❑
GLAUCOMA	❑	❑
HEADACHES	❑	❑
HEART ATTACK OR HEART DISEASE	❑	❑
HEART MURMUR	❑	❑
HEART PACEMAKER	❑	❑
HEPATITIS	❑	❑
HERPES	❑	❑
HIGH BLOOD PRESSURE	❑	❑
KIDNEY DISEASE	❑	❑

	YES	NO
LIVER PROBLEMS OR JAUNDICE	❑	❑
MAJOR SURGERY	❑	❑
MALIGNANCIES OR TUMORS	❑	❑
MEDICAL TREATMENT WITH RADIATION	❑	❑
NEUROLOGICAL PROBLEMS	❑	❑
PSYCHIATRIC CARE/ EMOTIONAL PROBLEMS	❑	❑
RECREATIONAL DRUG USE	❑	❑
RESPIRATORY PROBLEMS/ TROUBLE BREATHING	❑	❑
RHEUMATIC HEART DISEASE	❑	❑
SEVERE INFECTION	❑	❑
SHORTNESS OF BREATH	❑	❑
STOMACH OR INTESTINAL ULCERS/COLITIS	❑	❑
STROKE	❑	❑
THYROID PROBLEM	❑	❑
TRANSPLANTS	❑	❑
TUBERCULOSIS	❑	❑
WEIGHT CHANGE IN THE LAST YEAR	❑	❑
<u>FOR FEMALES:</u> PREGNANCY	❑	❑
ARE YOU TAKING BIRTH CONTROL PILLS	❑	❑

DO YOU HAVE ANY DISEASE, CONDITION OR HANDICAP NOT LISTED ABOVE? ____________________

____

Review Medical History: Date ____________ Changes ____________________
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LAHAINA SMILES
DENTAL

STEVE BARBA, D.M.D. GLENN KADOHIRO, D.D.S.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize LAHAINA SMILES DENTAL to provide any insurance company(ies), claim administrator(s) and consulting health care professionals with information concerning health care, advice, treatment, or supplies provided. This information will be used exclusively for the purpose of evaluating and administering for benefits.

I hereby authorize payment of dental benefits directly to LAHAINA SMILES DENTAL.

____
Print – Patient's Name

____
Signature – Patient or Authorized Guardian

____
Date

154 Papalaua St., Suite 200 | Lahaina, Hawaii 96761 | 808-667-7711

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Glenn Y. Kadohiro, DDS. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Glenn Y. Kadohiro, DDS reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION		
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)		
Spouse only	☐ **YES**	☐ **NO**
OR		
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	☐ **YES**	☐ **NO**
Any Member of my extended family: (Parents, Grandchildren)	☐ **YES**	☐ **NO**
Other: ______________________	☐ **YES**	☐ **NO**
Name of patient (please print): ______________________		
Patient signature: ______________________		
Patient's personal representative: (Please Print): ______________________		
Personal Representative's signature: ______________________		
Representative's Telephone Number: ____________ **Date:** ____________		

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	☐ **YES**	☐ **NO**	**Date Statement Provided:** ____________
Reason for not obtaining patient signature	☐	**Needed more time to review Statement**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	

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