PATIENT ID # _____

Hawaii Orthodontist
WE MAKE PEOPLE SMILE :)™

We are pleased to welcome you to our office. Please fill out this form as completely as you can.
We look forward to a pleasant and professional relationship with you.

MINOR PATIENT HISTORY FORM Date _____

PATIENT INFORMATION

Last Name _____ First _____ Middle _____

Nickname _____ Birthdate _____ Age _____

Gender: ☐ MALE ☐ FEMALE School _____ Grade _____

Home Address: Street _____ City _____ State _____ Zip _____

Phone: Mobile _____ Home _____ Work _____

Email _____ SSN # _____

INFORMATION - MOTHER

Last Name _____ First _____ Middle _____

Birthdate _____ Age _____ SSN # _____

Phone: Mobile _____ Home _____ Work _____

Email _____

Employer _____ Occupation _____

Business Address: Street _____ City _____ State _____ Zip _____

INFORMATION - FATHER

Last Name _____ First _____ Middle _____

Birthdate _____ Age _____ SSN # _____

Phone: Mobile _____ Home _____ Work _____

Email _____

Employer _____ Occupation _____

Business Address: Street _____ City _____ State _____ Zip _____

GENERAL INFORMATION

How did you hear about our office? ☐ dentist ☐ family ☐ friend ☐ online ☐ other _____

If referred by someone, whom may we thank? _____

Which office is more convenient for you? ☐ Ala Moana ☐ Kunia

ORTHODONTIC INSURANCE INFORMATION

PRIMARY INSURANCE

Name of insured _____

Name of insurance _____

Group # _____

Subscriber # _____

Effective date _____

SECONDARY INSURANCE

Name of insured _____

Name of insurance _____

Group # _____

Subscriber # _____

Effective date _____

Patient Signature _____

Parent Signature _____

PATIENT ID # _____

PATIENT MEDICAL HISTORY

Physician _____ Phone # _____ Date of last exam _____

Physician Address: Street _____ City _____ State _____ Zip _____

Emergency Contact _____ Relationship _____ Phone # _____

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

☐ Anemia	☐ Rheumatic Fever	☐ Fainting spells / Seizures
☐ Heart Ailments	☐ Blood Diseases	☐ Sinus Trouble
☐ High Blood Pressure	☐ Hepatitis, Jaundice	☐ Rheumatism / Arthritis
☐ Respiratory Disease	☐ HIV / AIDS	☐ Head Injuries
☐ Tuberculosis	☐ Kidney / Liver Disease	☐ Stomach Ulcers
☐ Nervous Disorders	☐ Tumors or Growths	☐ Tonsils removed
☐ Diabetes	☐ Tonsils / Adenoids removed	☐ Epilepsy
☐ Excessive bleeding	☐ Allergies (latex / metal)	☐ Stroke
☐ Osteoporosis	☐ Asthma or Hay Fever	☐ Disabilities
☐ Bone disorder or bone loss	☐ Joint replacement	☐ Pregnant (Women)

Have you ever been hospitalized or had a serious illness? Yes No _____
Do you use tobacco, alcohol, cocaine or other drugs? Yes No _____
Are you under a physician's care now? Yes No _____
Are you sensitive or allergic to any drugs? Please list. Yes No _____
Are you taking any medications or vitamins? Please list. Yes No _____

PATIENT DENTAL HISTORY

Dentist _____ Phone # _____ Date of last exam _____

Dentist Address: Street _____ City _____ State _____ Zip _____

If female, has menstruation started? If so, when? Yes No _____
If male, has voice changed or is facial hair present? Yes No _____
Have you ever had complications from dental extractions? Yes No _____
Do your gums bleed excessively? Yes No _____
Do you have cold sores, blisters or swelling on gums/lips/cheeks? Yes No _____
Do you suffer from headaches? If yes, how often? Yes No _____
Any difficulty breathing through your nose or difficulty swallowing? Yes No _____
Any pain or clicking in your jaw joint? Yes No _____
Are you aware of clenching or grinding of your teeth? Yes No _____
Do you have any speech problems? Yes No _____
Any accidents to your jaws, face or teeth? Yes No _____
Have you had previous orthodontic treatment? If so, with whom? Yes No _____
Has anyone else in your family had orthodontic treatment? Yes No
If yes, please list: _____

What is the patient's/parent's main orthodontic concern?

_____

Is there anything else in your dental/medical history we need to know when considering your treatment?

_____

I, the undersigned, believe the above information to be complete and accurate. If there are any changes to this history in the future I will inform the Hawaii Orthodontist office.

Parent Signature _____ Date _____

Form Updates _____ Office Initial _____ Date _____

Form Updates _____ Office Initial _____ Date _____

Form Updates _____ Office Initial _____ Date _____

Hawaii Orthodontist
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Tammy Chang-Motooka DDS, MS
Shelliann Kawamoto DDS, MS
Bryson Nakatani DDS, MS

PRIVACY CONSENT

This form is required by the new patient privacy regulations recently issued by the United States Depart of Health and Human Services. Prior to commencing your orthodontic treatment, you must review, sign and date this form.

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office's privacy notice prior to signing this Consent, a copy of which is posted in our office.

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to effective date of the revised notice.
You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

Thank you for your cooperation. Please let us know if you have any questions.

_____
Patient's Name (please print)

_____
Patient/Parent Signature (if patient is a minor)

_____
Date

Hawaii Orthodontist
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Tammy Chang-Motooka DDS, MS
Shelliann Kawamoto DDS, MS
Bryson Nakatani DDS, MS

AUTHORIZATION TO RELEASE INFORMATION

Dentist's Name: Tammy Chang-Motooka, DDS, MS, Inc.

I hereby authorize the above named dentist(s) to provide any insurance company(s), claim administrator(s), and consulting health care professional(s), information concerning health care advice, treatment, or supplies provided. This information will be used exclusively for the purpose of evaluating and administering claims for benefits.

_____
Patient's Name

_____
Parent or Guardian's Name

_____
Patient/Parent or Authorized Guardian's Signature

_____
Date

Hawaii Orthodontist
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Tammy Chang-Motooka DDS, MS
Shelliann Kawamoto DDS, MS
Bryson Nakatani DDS, MS

Consent for Treatment of Minor

This will authorize Dr. Tammy Chang-Motooka and other physicians under her supervision to provide medical care including examination, treatment, X-ray examination, photography, and treatment diagnosis to

_____/_____, a minor.
Patient's Name DOB

It is understood that this authorization is given in advance of any specific diagnosis and treatment in order to avoid delay in providing such treatment as is deemed necessary by Dr. Tammy Chang-Motooka and Dr. Shelliann Kawamoto.

This authorization to treat will remain in effect until patient is 18 years of age unless revoked sooner in writing.

_____ _____
Date Signature of Parent / Legal Guardian / Person having legal custody

_____
Print Name of Parent / Legal Guardian / Person having legal custody

_____
Relationship (if signed by other than parent)

_____ ☐ This form authorizes said minor to present for orthodontic treatment unaccompanied by adult.
Initials

_____ ☐ This form authorizes said minor to present for minor care and treatment accompanied by an adult other than his/her parent or legal guardian.
Initials