



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.

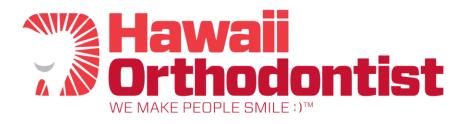
	ADULT PATIENT HISTORY FORM		Date		
PATIENT INFORMATION					
Last Name	First		Middle		
Nickname	Birthdate		Age		
Gender: 🗆 MALE 🗆 FEMALE	Marital Status:	□ Married □	Single 🗆 Divo	orced	
Home Address: Street		City	State	e Zip	
Phone: Mobile	Home		Work		
Email		_ SSN #			
Employer		Occupation			
Business Address: Street		_City	State	Zip	
SPOUSE INFORMATION					
Last Name	First		Middle		
Birthdate	Age		SSN #		
Home Address: Street		City	State	e Zip	
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 🗆 onli	ne 🗆 other		
If referred by someone, whom may	we thank?				
Which office is more convenient for	you? 🛛 🗆 Ala Moa	ana 🛛 🗆 Kur	ia		
ORTHODONTIC INSURANCE INFORM	IATION				
PRIMARY INSURANCE		SE	CONDARY INS	URANCE	
Name of insured		Name of insured			
Name of insurance		Name of insuran	ce		
Group #		Group #			
Subscriber #		Subscriber #			
Effective date		Effective date			
Patient Signature		Da	te		
Patient Signature		Da			

PATIENT ID # _____

PATIENT MEDICAL HISTORY

Physician	Phone #			_ Date of last exam	
Physician Address: Street	City		City	v State Zip	
Emergency Contact	Relation	nship		Phone #	
 Do you have, or have you had any of th Anemia Heart Ailments High Blood Pressure Respiratory Disease Tuberculosis Nervous Disorders Diabetes Excessive bleeding Osteoporosis Bone disorder or bone loss 	 he following: Rheumatic Fever Blood Diseases Hepatitis, Jaundice HIV / AIDS Kidney / Liver Disease Tumors or Growths Tonsils / Adenoids ren Allergies (latex / metal Asthma or Hay Fever Joint replacement 	noved		 Fainting spells / Seizures Sinus Trouble Rheumatism / Arthritis Head Injuries Stomach Ulcers Tonsils removed Epilepsy Stroke Disabilities Pregnant (Women) 	
Have you ever been hospitalized or had Do you use tobacco, alcohol, cocaine of Are you under a physician's care now? Are you sensitive or allergic to any drug Are you taking any medications or vitar	or other drugs? □ Yes □ Yes gs? Please list. □ Yes	 No No No 			
PATIENT DENTAL HISTORY					
Dentist	Phone #			_ Date of last exam	
Dentist Address: Street			City	ty State Zip	
Do you suffer from headaches? If yes, Any difficulty breathing through your no Any pain or clicking in your jaw joint? Are you aware of clenching or grinding Do you have any speech problems? Any accidents to your jaws, face or tee Have you had previous orthodontic treat Has anyone else in your family had orth If yes, please list:	dental extractions? elling on gums/lips/cheeks? how often? ose or difficulty swallowing? of your teeth? th? atment? If so, with whom? hodontic treatment?	 Yes 			
What is the patient's main orthodontic of					
Is there anything else in your dental/me	edical history we need to kn	ow wher	n coi	onsidering your treatment?	
I, the undersigned, believe the above ir the future I will inform the Hawaii Ortho		nd accu	irate	e. If there are any changes to this history	in
Patient Signature				Date	
Form Updates					
Form Updates	Office Init	tial		_ Date	

Form Updates _____ Office Initial _____ Date _____



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.

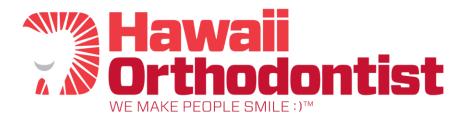
You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

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



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