



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.

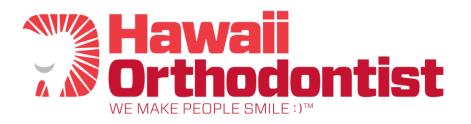
	ADULT PATIENT HISTORY FORM		Date				
PATIENT INFORMATION							
Last Name	First		Middle				
Nickname	Birthdate		Age				
Gender: 🗆 MALE 🗆 FEMALE	Marital Status: 🗆 Marrie		d 🗆 Single 🗆 Divorced				
Home Address: Street		City	Sta	ate Zip			
Phone: Mobile	Home		Work				
Email		_SSN #					
Employer		Occupation					
Business Address: Street		_City	State	Zip			
SPOUSE INFORMATION							
Last Name	First		Middle				
Birthdate	Age		SSN #				
Home Address: Street		City	Sta	ite Zip			
Phone: Mobile	Home		Work				
Email		<u> </u>					
Employer		Occupation					
Business Address: Street		City	State	Zip			
GENERAL INFORMATION							
How did you hear about our office?	□ dentist □ family	□ friend □ on	line $\Box$ other _				
If referred by someone, whom may w	ve thank?						
Which office is more convenient for	you? 🛛 Ala Moa	ana 🗆 Ku	nia				
ORTHODONTIC INSURANCE INFORM	ATION						
PRIMARY INSURANCE		SECONDARY INSURANCE					
Name of insured		Name of insured					
Name of insurance		Name of insurance					
Group #	Group #						
Subscriber #	bscriber #			Subscriber #			
Effective date		Effective date					
Patient Signature			ate				
		Da		·			

PATIENT ID # \_\_\_\_\_

## PATIENT MEDICAL HISTORY

Physician	Phone #		Date of last exam				
Physician Address: Street		City _		State Zip			
Emergency Contact	Relation	nship		Phone #			
<ul> <li>Do you have, or have you had any of th</li> <li>Anemia</li> <li>Heart Ailments</li> <li>High Blood Pressure</li> <li>Respiratory Disease</li> <li>Tuberculosis</li> <li>Nervous Disorders</li> <li>Diabetes</li> <li>Excessive bleeding</li> <li>Osteoporosis</li> <li>Bone disorder or bone loss</li> </ul>				<ul> <li>Fainting spells / Seizures</li> <li>Sinus Trouble</li> <li>Rheumatism / Arthritis</li> <li>Head Injuries</li> <li>Stomach Ulcers</li> <li>Tonsils removed</li> <li>Epilepsy</li> <li>Stroke</li> <li>Disabilities</li> <li>Pregnant (Women)</li> </ul>			
Have you ever been hospitalized or have 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 Served Yes Yes	<ul> <li>No</li> <li>No</li> <li>No</li> </ul>					
PATIENT DENTAL HISTORY							
Dentist	Phone #			_ Date of last exam			
Dentist Address: Street			City	y 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? nodontic treatment?	<ul> <li>Yes</li> </ul>					
What is the patient's main orthodontic of							
Is there anything else in your dental/me	edical history we need to kno	ow wher		onsidering 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.							
Patient Signature				Date			
Form Updates							
Form Updates	Office Initial		_ Date				

Form Updates \_\_\_\_\_ Office Initial \_\_\_\_\_ Date \_\_\_\_\_



Tammy Chang-Motooka D.D.S., M.S. Shelliann Kawamoto D.D.S., M.S.

## 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.

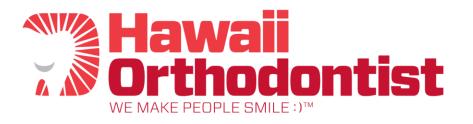
You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

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 D.D.S., M.S. Shelliann Kawamoto D.D.S., M.S.

## 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