PATIENT ID # __________

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 ☐ Divorced

Home Address: Street ________________ City ________ State ______ 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 ______ 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 ☐ 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 ________________ Date ________________

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 ________

Have you ever been treated for periodontal (gum) disease? ☐ 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 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.

Patient Signature ______________________________________ Date ____________________

Form Updates ______________________________ Office Initial _______ Date ____________________

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

Hawaii Orthodontist

WE MAKE PEOPLE SMILE :)™

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