



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.

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

SECONDARY INSURANCE

Name of insured _____
Name of insurance _____
Group # _____
Subscriber # _____
Effective date _____

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:

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

PRIVACY CONSENT

This form is required by the new patient privacy regulations recently issued by the United States Department 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

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

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)

Initials
 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.