MEDICAL HISTORY

Name _____ Date of Birth _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please list: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No _____
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ◯	Cortisone Medicine ◯	Hemophilia ◯	Renal Dialysis ◯
Alzheimer's Disease ◯	Diabetes ◯	Hepatitis A ◯	Rheumatic Fever ◯
Anaphylaxis ◯	Drug Addiction ◯	Hepatitis B or C ◯	Rheumatism ◯
Anemia ◯	Easily Winded ◯	Herpes ◯	Scarlet Fever ◯
Angina Arthritis/Gout ◯	Emphysema ◯	High Blood Pressure ◯	Shingles ◯
Artificial Heart Valve ◯	Epilepsy or Seizures ◯	Hives or Rash ◯	Sickle Cell Disease ◯
Artificial Joint ◯	Excessive Bleeding ◯	Hypoglycemia ◯	Sinus Trouble Spina Bifida ◯
Asthma ◯	Excessive Thirst ◯	Irregular Heartbeat ◯	Stomach/Intestinal Disease ◯
Blood Disease ◯	Fainting Spells/Dizziness ◯	Kidney Problems ◯	Stroke ◯
Blood Transfusion ◯	Frequent Cough ◯	Leukemia ◯	Swelling of Limbs ◯
Breathing Problem ◯	Frequent Diarrhea ◯	Liver Disease ◯	Thyroid Disease ◯
Bruise Easily ◯	Frequent Headaches ◯	Low Blood Pressure ◯	Tonsillitis ◯
Cancer ◯	Genital Herpes ◯	Lung Disease ◯	Tuberculosis ◯
Chemotherapy ◯	Glaucoma ◯	Mitral Valve Prolapse ◯	Tumors or Growths ◯
Chest Pains ◯	Hay Fever ◯	Pain in Jaw Joints ◯	Ulcers ◯
Cold Sores/Fever Blisters ◯	Heart Attack/Failure ◯	Parathyroid Disease ◯	Venereal Disease ◯
Congenital Heart Disorder ◯	Heart Murmur Heart ◯	Psychiatric Care ◯	Yellow Jaundice ◯
Convulsions ◯	Pace Maker Heart ◯	Radiation Treatments ◯	◯
◯	Trouble/Disease ◯	Recent Weight Loss ◯	

Have you ever had any serious illness not listed above? ◯ Yes If yes, please explain: _____

Have you ever taken or are you taking Bone Growth Medication (ex. Boniva)? ◯ Yes ◯ No

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder ☐ Responsible Party

Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____

E-mail: _____

Section 2 Section 3

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Referred by: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____

Spouse's name: _____

Spouse's phone #: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

FINANCIAL AGREEMENT

Dean S. Arashiro, DDS, MS, LTD

PAYMENT for SERVICES

Payment for services is due at the time services are rendered. You are responsible for all charges you incur regardless of your insurance coverage. We will always recommend treatment based upon your periodontal needs, not based on insurance coverage, which is almost always inadequate. Dental insurance is a benefit used to assist you, not to dictate necessary treatment. For insurance other than HDS and HMSA, payment will be collected in full. Your insurance company will send any reimbursements to you directly.

We accept cash, personal checks, debit cards, Visa, Master Card, American Express, and Discover. We also offer financing through Care Credit.

FINANCE CHARGES

A 1.5% finance charge will be applied to all balances not paid within 30 days of the monthly billing date. Collection action will be taken on any balance due over 60 days.

MISSED APPOINTMENTS

Your scheduled appointment has been reserved especially for you. We realize that unexpected events do occur, but request that any changes be made 48 hours in advance. There is a $50 charge for missed appointments and last minute cancellations.

RETURNED CHECKS

A $25 charge applies when a check is returned by the bank.

RECORDS

Original records, including x-rays, are the property of this office. We will provide you with a copy for a nominal duplication fee.

CONSENT

I consent to the performance of the necessary dental treatment deemed advisable. I will be responsible for fees associated with those procedures even in the event my insurance carrier does not cover the full amount.

_____ _____

Patient's Signature Date

Dean S. Arashiro, DDS, MS, LTD

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect immediately, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.10 for each page, $15 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dean S. Arashiro, DDS, MS

Telephone: 808-893-0880 Fax: 808-893-0881

E-mail: mauigumdocoffice@gmail.com

Address: 135 S. Wakea Avenue, Suite 211, Kahului, Hawaii 96732

Dean S. Arashiro, DDS, MS, LTD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____