DIAMOND HEAD
DENTAL CARE
A Reason to Smile

HOW DID YOU HEAR ABOUT US?

- ☐ Passing by our office
- ☐ Current patient: _____
- ☐ Insurance website:_____
- ☐ Google Search: _____
- ☐ Yelp
- ☐ Other: _____
- ☐ A brochure or flyer from our office
- ☐ Social Media: Facebook/Instagram/Google+
- ☐ Office website
- ☐ Fast Braces website
- ☐ CareCredit website
- ☐ Honolulu Best Dentist (Honolulu Magazine)
- ☐ American Dental Association
- ☐ Invisalign website

PATIENT INFORMATION

Name:_____ Preferred Name:_____

Social Security#:_____ Date of Birth:_____ Sex:_____ Marital Status:_____

Mailing Address:_____
(street address) (apt #) (city) (state) (zip)

Cell Phone:_____ Home Phone:_____ Email:_____

Occupation & Employer:_____ Business Phone:_____

INSURANCE SUBSCRIBER INFORMATION (If other than yourself)

Subscriber Name:_____ Relationship to Patient_____

Social Security#:_____ Date of Birth:_____ Phone:_____

Mailing Address:_____
(street address) (apt #) (city) (state) (zip)

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:_____ Relationship to Patient:_____

Mailing Address:_____ Telephone:_____

The information provided on this form is accurate to the best of my knowledge. My signature on this form acknowledges that I understand that I am financially responsible for all charges. If there is insurance involvement I further understand that I am financially responsible for all charges not paid by my insurance company. My signature also grants permission for this practice to file insurance claims on my behalf, releasing information as needed and authorizes my insurance company to make payments directly to Diamond Head Dental Care. My signature also grants that Diamond Head Dental Care may contact me on my cell phone by calling, leaving a voicemail and texting.

*Signature:*_____ *Date:*_____
patient or parent/guardian if minor

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I, _____, have been presented with this office's Notice of Privacy Practices. If you wish to have a copy of our Privacy Practices, please let us know. You may refuse to sign this acknowledgement.

*Signature:*_____ *Date:*_____
patient or parent/guardian if minor

3045 Monsarrat Avenue | Suite 7 | Honolulu, HI 96815 | Phone: 808.735.8883 | Fax: 808.732.0240
Email: DiamondHeadDentalCare@gmail.com | www.DiamondHeadDentalCare.com

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PATIENT CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE

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 that you will be receiving.

What is your main dental concern for this visit?_____

_____

Medical doctor's name_____Phone #_____

Are you under a doctor's care now? Yes No Why?_____

Have you been hospitalized or received a blood transfusion? Yes No Why and when?_____

_____

Are you taking any medications, pills, drugs, vitamins or herbal remedies? Yes No Please list on the following line:

_____

Are you allergic to any medications or substance? Yes No What?_____

(Women) Are you pregnant? Yes No How many months?_____Excessive thirst_____

Do you use tobacco product in any form?_____

Please **CIRCLE** if you have had any of the following:

AIDS or HIV +	Chest Pain	Hay Fever	Liver Disease	Sinus Trouble
Allergies (other than seasonal)	Congenital Heart Lesion	Heart Murmur	Low Blood pressure	Sleep Apnea
Alzheimer's disease	Cold Sores	Heart Surgery	Lung Disease	Snoring
Anemia	Cortisone Medicine	Heart Trouble	Nervousness	Stroke
Arthritis / Gout	Diabetes	Hemophilia	Pacemaker	Swelling of Feet/Hands
Artificial Heart Valve	Drug Addiction	Hepatitis A	Pain in Jaw Joints	Thyroid Disease
Asthma	Emphysema	Hepatitis B	Parathyroid Disease	Trouble Sleeping
Artificial Joints/Hips	Epilepsy or seizures	Hepatitis C	Psychiatric Care	Tuberculosis TB
Blood Disease	Excessive thirst	Herpes	Recent Weight Loss	Ulcers
Blood Transfusion	Fainting or Dizziness	High Blood Pressure	Rheumatism	Venereal Disease
Bruise Easily	Fever Blisters	Hypoglycemia	Rheumatic Fever	X-ray / Cobalt Treatment
Cancer	Frequent Cough	Kidney Disease	Shortness of Breath	Yellow Jaundice
Chemotherapy/Radiation	Glaucoma	Latex Allergy	Sickle Cell Anemia	

Have you ever had any other serious illness not circled above? Yes No Please describe on line below:

_____

Do you wish to speak to the Doctor privately about any medical problem? Yes No

I certify that the information listed above is complete and accurate. I acknowledge that I will notify the Doctor and the Diamond Head Dental Care team if I wish to speak in private at any time about my care.

*Signature:*_____ *Date:*_____

patient or parent/guardian if minor

*Doctor Signature:*_____ *Date:*_____

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