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
- ☐ Facebook
- ☐ Office website
- ☐ Invisalign website
- ☐ CareCredit website
- ☐ Honolulu Best Dentist (Honolulu Magazine)
- ☐ American Dental Association
- ☐ Hawaii Dental Association

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. I agree to confirm my appointments a week in advance when prompted via text, email or call, otherwise my appointment will not be guaranteed. I understand a late cancel/no show fee will be assessed if I change my appointment within 48 hours of its scheduled date/time.

*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	Glaucoma	Latex Allergy	Sickle Cell Anemia
Allergies (other than seasonal)	Congenital Heart Lesion	Hay Fever	Liver Disease	Sinus Trouble
Alzheimer's disease	Cold Sores	Heart Murmur	Low Blood pressure	Sleep Apnea
Anemia	Cortisone Medicine	Heart Surgery	Lung Disease	Snoring
Arthritis / Gout	COVID-19/coronavirus	Heart Trouble	Nervousness	Stroke
Artificial Heart Valve	Diabetes	Hemophilia	Pacemaker	Swelling of Feet/Hands
Asthma	Drug Addiction	Hepatitis A	Pain in Jaw Joints	Thyroid Disease
Artificial Joints/Hips	Emphysema	Hepatitis B	Parathyroid Disease	Trouble Sleeping
Blood Disease	Epilepsy or seizures	Hepatitis C	Psychiatric Care	Tuberculosis TB
Blood Transfusion	Excessive thirst	Herpes	Recent Weight Loss	Ulcers
Bruise Easily	Fainting or Dizziness	High Blood Pressure	Rheumatism	Venereal Disease
Cancer	Fever Blisters	Hypoglycemia	Rheumatic Fever	X-ray / Cobalt Treatment
Chemotherapy/Radiation	Frequent Cough	Kidney Disease	Shortness of Breath	Yellow Jaundice

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

Do you wish the Doctor to review proactive options for your dental health during your exam? 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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Diamond Head Dental Care

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 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 privacy practices that are described in this Notice while it is in effect. This notice takes effect July 16, 2014 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 policies, 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. We are not responsible for the re-disclosure and privacy practices of other offices and healthcare providers.
- 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, 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 personal 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 text messages, 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 electronically. We will use that 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, we will charge you $25.00 for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternate 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 insurances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for up to the last 6 years, but not before January 1, 2012. 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.

RESTRICTIONS: 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 COMMUNICATIONS: 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.

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 if this Notice. You may also submit a written complaint to the U.S Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S Department of Health and Human Services upon request.

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: Krista Matto, Telephone: 808-735-8883, Fax: 808-732-0240, Email: DiamondHeadDentalCare@gmail.com