

Aloha Dental

Patient Information:

Full Name: _____

Street Address: _____

City _____ State _____ Zip Code: _____

Home Phone: _____ Work _____ Cell: _____

Birth Date: _____ Social Security # _____

Sex: Male Female

Responsible Party: Fill out if the responsible party is someone other than the patient

Full Name: _____

Address: _____

Home Phone: _____ Work: _____ Cell: _____

Birth Date: _____

Insurance Information:

Name of Insured: _____

Patient's Relationship to insured (circle): Self Spouse Dependent Other _____

*Insured's address is the same as: () patient's address () responsible party's address

Insured's Street Address: _____

City _____ State _____ Zip Code: _____

Insured Social Security _____

Insured Birth Date: _____

Insured Phone Number: _____

Employer: _____ City/State _____

Insurance Company: _____

Emergency Contact: _____ Phone: _____

Who should we thank for referring you? (please circle one)

Newspaper Flyer TV Commercial Online Your Insurance Company

Other: _____

Aloha Dental

Mark Jumper, D.D.S.

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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 explain: _____
- 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 No Known Allergies
- Other If yes, please explain: _____

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

- | | | | |
|--|--|--|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No | Hemophilia <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No | Diabetes <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No | Rheumatism <input type="radio"/> Yes <input type="radio"/> No |
| Anemia <input type="radio"/> Yes <input type="radio"/> No | Easily Winded <input type="radio"/> Yes <input type="radio"/> No | Herpes <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No |
| Angina <input type="radio"/> Yes <input type="radio"/> No | Emphysema <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Shingles <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No |
| Asthma <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No | Leukemia <input type="radio"/> Yes <input type="radio"/> No | Stroke <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No | Liver Disease <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No | Lung Disease <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No |
| Cancer <input type="radio"/> Yes <input type="radio"/> No | Glaucoma <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No | Hay Fever <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No | Ulcers <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pace Maker <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No | |

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

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 _____



**Health Insurance Portability Act (HIPAA)
Acknowledgment Form**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Aloha Dental to use and disclose my protected health information to carry out:

Treatment, including direct or indirect treatment by other healthcare providers involved in my treatment

Obtaining payment from third party payers, e.g. patient's insurance company

The day-to-day healthcare operations of Aloha Dental.

I have also been informed of, and given the right to review and secure a copy of Notice of Privacy Practice, which contains a more complete description of the used and disclosures of my protected health information, and my rights under HIPAA. I understand that Aloha Dental reserves the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of the notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that Aloha Dental is not required to agree to these requested restrictions. However, if Aloha Dental does agree, then they are bound to comply with this restriction.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Responsible Party's Signature: _____ **Date:** _____

Print Name: _____

Patient's Name: _____



Aloha Dental's Financial Policies

We believe in the importance of quality dental care, and we strive to provide the best dental treatment possible. Also, we understand the financial limitations that influence your choice of care. We want to assure you of our flexible approach to financing.

We work with most insurance companies, and we always try to maximize your coverage through meticulous detailing of procedures and interactions with your insurer. We even fill out your claim forms, and we're available to answer any questions we can.

Please remember, however, that *you are responsible for the portion of your treatment not covered by insurance*. Because we too must balance our finances, we do ask that you pay your portion of the bill at the time of treatment. If you qualify, we'll work with you to devise a method of payment that works for both of us. We also accept most major credit cards.

We hope that you find this information useful. Rest assured that we are here to help make quality dental care obtainable for all. We look forward to working with you to achieve excellent dental health.

We consider the time set aside for your appointment to be yours alone. For this reason, we never double book our schedule or accept drop-ins, except in emergencies. Consequently, when you cancel your appointment, especially at the last minute, our entire practice is affected.

We understand that cancellations are sometimes necessary, but we all pay the price for last-minute cancellations. Plus, when you routinely miss appointments, your dental health suffers as well.

Not only are we committed to bringing you the very best professional and personal care that we can, we also place value on your time. Please pay us the same respect by giving us enough advance notice when you cancel an appointment so that we can use that time for the benefit of our other patients. *Note: A \$50 cancellation charge may be applied to your account if a 24-48 hour notice is not given.*

Sincerely,

Dr. Mark W. Jumper II

I acknowledge and agree to the above policies.

Signature: _____ Date: _____

Print Name: _____

Patient's Name: _____