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 _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ 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 ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

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

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

Have you ever had any serious illness not listed above? ◯ 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 _____

Aloha Dental

Patient Information:

Full Name: _____

Street Address:_____

City_____ State_____ Zip Code: _____

Home Phone: _____ Work _____Cell:_____

Birth Date: _____ Social Security #_____

Sex: Male Female Email Address_____

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

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

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: _____

Aloha Dental

Oral Cancer Enhanced Screening

Insurance does not pay for everything, even services that you and your dentist have good reason to think you need.

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health for our patients.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors, but more than 25% of oral cancer victims have no such lifestyle risk factors. Studies also suggest that human papilloma virus (HPV 16/18) plays a role in more than 20% of oral cancer cases.

We have incorporated the VELscope Vx into our oral screening standard of care. We find that using VELscope Vx along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. VELscope Vx is similar to proven early detection procedures for other cancers such as mammography, Pap smear and PSA. It is a simple and painless examination that gives the best chance to find any oral abnormalities at the earliest possible stage. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possible save your life. The exam will be offered to you annually.

◯ Yes, I authorize the enhanced examination which is recognized by the American Dental Association. This exam might not be covered by your insurance. The fee for this enhanced examination is $30.

◯ No, I would prefer not to have the VELscope Vx exam at this time. I hereby release from liability Aloha Dental dentists, hygienists, employees or agents from any injury I may currently, or in the future suffer as a result of my refusal to proceed.

_____

Date

_____

Signature of Responsible Party

Aloha Dental

NON-COVERED INSURANCE EXAMS WAIVER

Insurance does not pay for everything, even services that you and your dentist have good reason to think you need. We do our best to keep up with your insurance company and get general copies of your coverage 48 hours prior to your appointment to make sure we have the most up to date information possible.

In this fast changing insurance world, even insurance companies are unable to keep up with their changes and refuse to guarantee anything until a claim is actually processed.

Insurance may or may not pay for some or all of the following services indicated below, despite our best efforts:

- Panoramic, Periapical and Bitewing x-rays (used for wisdom teeth, emergency evaluations, periodontal disease, bone loss, infection and carries detection)
- Resin, or tooth colored fillings (insurance may down-grade to cost of amalgam or silver fillings)
- Waiting periods for treatment (periodontal disease, lost or broken crowns and veneers, root canal treatment, to name a few)
- Tooth colored crowns
- Intravenous Conscious Sedation, Nitrous gas sedation, or other medicaments.
- Policy cancelled for any reason.
- Frequency Limits
- Cancer Screenings
- Any other reason_____.

By signing below, you authorize these services to be completed. You understand that you are responsible for any balance your insurance may not pay due to their reimbursement policies they may have with your employer.

We will help appeal any claim that is unpaid. In the end, if insurance does not pay, you promise you will.

_____

Date

_____

Signature of Responsible Party