Tropical Smiles Dental

Melissa M Nitta, DDS

Date: _____

Patient's Sex ☐F ☐M

Patient Information

Name _____ Preferred Name _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Drivers License # _____ Cell Phone _____ Home Phone _____

Email _____ SSN _____

Please check the appropriate box: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Who may we thank for referring you? _____

Patient or Parent/Guardians Employer _____ Work phone _____

Spouse or Parent/Guardians Name _____ Cell Phone: _____

Person to Contact in Case of Emergency _____

Relationship to Patient _____ Cell Phone: _____

Is the patient financially responsible for their own account? ☐Yes ☐No

If no, complete the following section.

Responsible Party

Name of person responsible for this account _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Email _____ Phone _____ Birthdate _____

Drivers License # _____ SSN _____

Insurance Information

Name of Insured _____ Birthdate _____

Insurance Company _____ SSN _____

Do you have any additional insurance? ☐Yes ☐No If yes, complete the following section.

Name of Insured _____ Birthdate _____

Insurance Company _____ SSN _____

75-5995 Kuakini Highway, Suite 121, Kailua Kona, HI 96740

Tel: (808) 329-1715 | Fax: (808) 329-1811

www.tropicalsmileshawaii.com

Patient Medical History

Medical Physician _____ Phone _____

	Yes	No
1. Are you under medical treatment now? ….....	□	□
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain:	□	□
3. Do you have a persistent cough or throat clearing not associated w/a known illness (lasting more then 3 weeks)?	□	□
4. Are you taking any medication(s) including non-prescription medicine? ……. If yes, what medication(s) are you taking?	□	□
5. Have you ever taken Fosamax, Boniva, Actonel or any canver medications containing bisphosphonates?	□	□
6. Do you use tobacco? ……	□	□
7. Do you use controlled substances? ……..	□	□
8. Are you wearing contact lenses?…….....	□	□

	Yes	No
9. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocaine) ……..	□	□
Penicillin ……	□	□
Other Antibiotics ……...	□	□
Sulfa Drugs ……	□	□
Barbiturates……	□	□
Sedatives ……	□	□
Aspirin ……...	□	□
Any Metals (e.g. nickel, mercury, etc) ……..	□	□
Latex Rubber ……..	□	□
Other: _____	□	□
10. Women Only:		
a) Are you pregnant or think you may be pregnant?	□	□
b) Are you nursing?	□	□
c) Are you taking oral contraceptives?	□	□

11. Do you have or have you had any of the following?	Yes	No		Yes	No		Yes	No
High Blood Pressure……	□	□	Heart Disease ……..	□	□	Chest Pains ……..	□	□
Heart Attack …….....	□	□	Cardiac Pacemaker ……..	□	□	Easily Winded ……	□	□
Rheumatic Fever……..	□	□	Heart Murmur ……..	□	□	Stroke ……..	□	□
Swollen Ankles ……...	□	□	Angina ……	□	□	Hay Fever / Allergies …….	□	□
Fainting / Seizures ……...	□	□	Frequently Tired ……..	□	□	Tuberculosis ……...	□	□
Asthma ……	□	□	Anemia ……...	□	□	Radiation Therapy ……	□	□
Low Blood Pressure ……	□	□	Emphysema ……	□	□	Glaucoma ……...	□	□
Epilepsy / Convulsions ……...	□	□	Cancer ……	□	□	Recent Weight Loss ……...	□	□
Leukemia ……..	□	□	Arthritis ……..	□	□	Liver Disease ……...	□	□
Diabetes ……...	□	□	Joint Replacement or Implant	□	□	Heart Trouble …….	□	□
Kidney Diseases ……..	□	□	Hepatitis A, B, or C/ Jaundice	□	□	Respiratory Problems …….	□	□
AIDS or HIV Infection ……...	□	□	Mitral Valve Prolapse ……	□	□	Other: _____	□	□
Thyroid Problem …….	□	□	Stomach Troubles / Ulcers ….	□	□			

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing? ……	□	□	8. Do you have frequent headaches?	□	□
2. Are your teeth sensitive to hot or cold liquids/foods?	□	□	9. Do you clench or grind your teeth? ……	□	□
3. Are your teeth sensitive to sweet or sour liquids/foods? ……	□	□	10. Do you bite your lips or cheeks frequently? …….	□	□
4. Do you feel pain to any of your teeth? …….....	□	□	11. Have you had any difficult extractions in the past?	□	□
5. Do you have any sores or lumps in or near your mouth? ……	□	□	12. Have you ever had any prolonged bleeding following extractions? …….	□	□
6. Have you had any head, neck or jaw injuries? ……	□	□	13. Have you had any orthodontic treatment? ……	□	□
7. Have you ever experienced any of the following problems in your jaw?			14. Do you wear dentures or partials? …….	□	□
Clicking ……..	□	□	15. Have you ever received oral hygiene instructions		
Pain (joint, ear, side of face) ……..	□	□	regarding the care of your teeth? …….	□	□
Difficulty in opening or closing ……	□	□	Do you like your smile? …….....	□	□
Difficulty in chewing ……..	□	□			

I understand that the information that I have given today is correct and to the best of my knowledge. I also understand that this information will be held in the strictest confidence and is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnoses and treatment, with my informed consent.

_____

_____

Signature of Patient (or Parent/Guardian if Minor) Date

Notice of Privacy Practices
Tropical Smiles Dental Melissa M. Nitta, DDS LLC

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 01/01/2017, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other

lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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 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.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Tropical Smiles Dental
Melissa M. Nitta, DDS
75-5995 Kuakini Highway, Suite 121
Kailua Kona, HI 96740

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental providers *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*. Importantly the updated 9-23-13 version of the NOPP reflecting the OMNIBUS rule.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ **Date:**_____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

_____

Additional Disclosure Authority:

OTHER – SPECIFY	Names	Signatures	ID

For office use only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

_____The patient refused to sign
_____Communication barriers
_____Emergency situation
_____Other

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME: _____

ADDRESS: _____

TELEPHONE: _____

EMAIL: _____ **SOCIAL SECURUITY #:** _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Tropical Smiles Dental
Melissa M. Nitta, D.D.S.
75-5995 Kuakini Hwy. Suite 121
Kailua Kona, HI 96740
(808) 329-1715

Right to revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above, Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ DATE: _____

If this consent is signed by a personal representative on behalf of the patient, then complete the following:

Personal Representative's Name: _____

Relationship to the Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the Patient's Chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat me after I have revoked my Consent.

Signature: _____ DATE: _____

PATIENT APPOINTMENT POLICY

When scheduling an appointment please remember that we have reserved this time especially for you or your family member. Our practice is dedicated to your quality care and we ask that you respect this time that has been reserved exclusively for you. Please arrive 10 minutes prior to your scheduled appointment time.

If you absolutely must cancel an appointment that you have reserved we require 48 business hours advance notice or a fee based upon the reserved appointment time may be charged to your account. *Please note that our office is* ***closed on Fridays*** *and an appointment for Monday will require cancelling by* ***Wednesday the week prior.***

As a courtesy, our practice confirms appointments 1-4 days in advance. If a message is left, we ask that you make every effort to return our confirmation call as soon as possible so that we may better serve our patient base.

PATIENT FINANCIAL POLICY

In order to maintain a good relationship with our patients, Melissa M. Nitta, DDS has adopted a written financial policy that is communicated to every patient. The purpose of this policy is to eliminate the confusion or misunderstanding concerning financial arrangements offered by our office.

For our patients with insurance benefits, please note that although we are happy to bill your insurance carrier as a courtesy, the contract exists between the carrier and the insured. We cannot guarantee payment of benefits. Any questions regarding your benefits should be directed to your insurance provider .

Payment at the time of service is expected. The patient, or legal guardian if the patient is a minor, is expected to pay the *ESTIMATED* portion of their copayment when treatment is rendered. Copayments are estimated for each visit. After insurance payment is received, you will be billed for any remaining balance. Payment is expected within 15 days of receipt of this treatment.

Your account will be considered delinquent if payment is not received within 30 days from the time of service; a late fee of 1.5% will be assessed and will appear on subsequent statements. The annual percentage rate is 18%.

A $35 charge will be billed to a patient's account for any check returned by the bank for any reason not paid. Once a check has been returned or an account has become delinquent we will accept only cash payments in full for further dental care at the time of service. Delinquent accounts will be sent to a collection agency, and collection fees will be added to your account.

Signature_____ Date_____

Tropical Smiles Dental
Melissa M Nitta, DDS

I hereby grant Melissa M. Nitta, DDS LLC permission to use my likeness in a photograph, video, or other digital media ("photo") in any and all of its publications, including web-based publications, without payment or other consideration.

I understand and agree that all photos will become the property of Melissa M. Nitta, DDS LLC and will not be returned.

I hereby irrevocably authorize Melissa M. Nitta, DDS LLC to edit, alter, copy, exhibit, publish, or distribute these photos for any lawful purpose. In addition, I waive any right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photo.

I hereby hold harmless, release, and forever discharge Melissa M. Nitta, DDS LLC all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I HAVE READ AND UNDERSTAND THE ABOVE PHIOTO RELEASE. I AFFIRM THAT I AM AT LEAST 18 YEARS OF AGE, OR, IF I AM UNDER 18 YEARS OF AGE, I HAVE OBTAINED THE REQUIRED CONSENT OF MY PARENTS/GUARDIANS AS EVIDENCED BY THEIR SIGNATURES BELOW.

I ACCEPT:

Print Name: _____ Signature: _____Date: __ / __ / ____

If under 18, both parents must sign individually and as parent/guardian.

Parent Signature: _____ | Date: __ / __ / ____

Parent Signature: _____ | Date: __ / __ / ____

I DECLINE:

Print Name:_____ Signature:_____ Date:__/__/___

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www.tropicalsmileshawaii.com

Tropical Smiles Dental
Melissa M Nitta, DDS

Welcome to Tropical Smiles Dental! We want to let you know about all the financial options that you have available with our office. Feel free to ask the front office team about more information to sign-up for any of the following options. Certain restrictions may apply when using special financing. For "major treatment" our office extends a discount with the treatment paid in-full one week prior to the appointment date. You will receive a 5% discount on the patient portion using cash or check and a 3% discount for credit card transactions.

CareCredit

Dr. Nitta offers a third -party payment plan called CareCredit with special financing options available upon credit approval. With CareCredit you would be able to make comfortable monthly payments to receive the recommended treatment you need right away. Applying is easy and convenient with instant approval by going online or a simple phone call.

planforhealth™
smarter dentistry for all

This new program is our own in-house dental service plan that we are able to offer to our established patients. Plan for Health is perfect for patients without insurance or patients expected to reach their annual maximum benefit coverage. This exclusive plan allows us to reward our loyal patients for keeping their dental health a priority.
Membership Benefits:

- Hygiene Visit every 3-6 months for adults, every 6 months for children
- All exams including periodic, emergency and comprehensive
- Four bitewings and two periapical digital x-rays
- 15% off all dental procedures and products

Benefits of our dental plan include:

- No annual maximum
- No deductible
- No wondering whether insurance will pay towards your treatment
- No waiting period-this means you can start treatment today!
- No pre-authorization is ever required!
- Cosmetic dentistry is included!!