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 cancer 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. Novacaine)	☐	☐
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
1. Do your gums bleed while brushing or flossing?.....	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?.....	☐	☐
3. Are your teeth sensitive to sweet of sour liquids/foods?.....	☐	☐
4. Do you feel pain to any of your teeth?.....	☐	☐
5. Do you have any sores or lumps in or near your mouth?.....	☐	☐
6. Have you had any head, neck or jaw injuries?.....	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing.....	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth?	☐	☐
Do you like your smile?	☐	☐

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

CONSENT FOR USE AND DISCOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME:_____

ADDRESS:_____

TELEPHONE:_____

EMAIL: _____**SOCIAL SECURITY #:**_____

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, DDS
75-5995 Kuakini Highway Ste 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 your 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 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 Representatives Name: _____
Relationship to the Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

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 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: _____

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 cai 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

PATIENT APPOINTMENT POLICY

When scheduling your 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 hours business advance notice or a fee based upon the reserved appointment time may be charged to your account. We do not accept changes to appointments via email or text as we may not receive the message.

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

PATIENT FINANCIAL POLICY

To maintain a good relationship with our patients Tropical Smiles Dental has adopted a written financial policy that is communicated with 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 is expected at the time of service. 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 at 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 payment. The patient is also responsible for payment of Hawaii General Excise Tax on the fees for services rendered.

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

A $35 charge will be billed to your account for any check returned by the bank for any reason not paid. Once a check has been returned or an account 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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